

Lonely voices: A grounded theory study into the experiences of family members and mental health staff after suicide.

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Abstract

The way in which family members are supported by staff from the mental services after the suicide of a relative is an important, though not well researched area. This research aims to explore two main areas; firstly to explore from the family members perspectives how they were supported by staff after the suicide of their relative and whether this was what they would have wanted as a means of support.

Secondly mental health staff were asked about what and how they provided support to families after the suicide of a relative and how they felt about what was provided by them and the service.

This research project presents a qualitative study using grounded theory analysis of data collected from family members and mental health staff members about their experiences after the death from suicide of a family member or patient receiving care from the mental health services.

The study sample comprised six staff and five family members who were interviewed face to face about what they experienced. The interviews were audiotaped and transcribed verbatim, then analysed in keeping with grounded theory, by using constant comparison of data, paying particular attention to reflexivity and researcher influence upon the data and ongoing analysis.

The core categories arising out of the analysis from the staff interviews showed that staff feel ill equipped to inform family members or provide support after their relative has died by suicide. More specifically the core categories presented the following key areas for staff as follows;

1. Training and awareness raising about suicide, including broadening understanding about the context within which suicide occurs.
2. The emotions involved with and related to the impact of suicide.
3. Skills and competence in breaking bad news to others including family members after suicide.
4. Including families in the care of people receiving mental health services.
5. Awareness and support with the formal processes that ensue following suicide.
6. Staff support after suicide, including managers, colleagues as well as staff in general in the organisation.

The core categories from the analysis of family members interviews showed, that;

1. Family members felt excluded and unheard by staff following the suicide of a relative. 2. Family members spoke about their fear for the future and the legacy of suicide. 3. The formal processes that take place after suicide were unclear and inconsistent for family members. 4. The emotional aftermath of suicide was significant however as core category 5 indicated, the family members experienced a mismatch between what they wanted and what they received from mental health staff and the organisation. Consequently core category 6. showed how their experience motivated the family members to speak out and join the research into this subject.

Conclusions are therefore set out with recommendations that promote guidance and training to mental health staff and services about ways to work with patients and families, incorporating current NHS policy, to improve staff skills and confidence; to 'attune' with patients and families, by including families in mental health care and afterwards if suicide happens, to which Family Therapy/systemic psychotherapy theory and practice could contribute in a variety of ways .

1. Introduction

1.1 Introduction

I would like to set the scene for this research and the context in which it has taken place with two quotes:

“With one thing, the coronial inquest was right; she was “extraordinary”. Our beloved daughter was indeed extraordinary and we have to come to terms with her loss, a loss that is still hard to comprehend and still seems to have been entirely preventable ... at least, at that point in her life. Natassya took her own life when she was 19 years old...” (Nichterlein, 2013, p. 30)

Words cannot do justice to the myriad of emotions evoked by suicide, and this quote reflects that difficulty. Each time I read the above excerpt I pause.

Thought does not seem possible when attempting to comprehend such an event.

“I found it risky to divulge, when asked how I was, the still tender feelings about the suicide, and how I was working my way through my reactions ... I talked about having had two other suicides earlier in my practice, and how I was still reeling from the effects of this one ... Yet there was lingering silence as there always is at these moments when I have just told ... just enough silence to leave me wishing I had not exposed myself. I should have left them guessing about the tired sadness in my face” (James in Weiner, 2005, p. 17)

The subject of suicide research is imbued with many words about feelings and emotions, from multiple perspectives, to which I will return throughout this thesis.

1.1.1 Beginning this research journey

As a family therapist and mental health nurse working predominantly in adult mental health services, I have often wondered what happens to people when they become mentally ill. I have thought a lot about the route individuals with mental illness take when accessing help and their onward progression, which some of the time entails admission to an inpatient ward for treatment and sometimes results in outpatient treatment.

I wondered about the effects of placing a person in virtual isolation in a hospital unit, away from familiar networks and connections, giving them treatment, then returning them to their homes. I observed over time that for some people who

were repeatedly admitted to the inpatient ward to maintain wellness something else needed to happen. The reasons some people remain well or do not are largely unknown to mental health services, and sometimes, when people in these situations end their life by suicide, I wondered how shocking this must have been for their friends and family and the people who had worked with them, and what sense they would be able to make of what had happened. Working in mental health one observes and experiences shocking events relatively frequently. Patient suicide became a regular feature of my career from early on. Consequently, I had many questions which were worked with in a fashion but were often left unanswered.

In the late 1970s and early 80s mental health organisations were generally arranged in accordance with the medical model. However, some little green shoots of systemic practice were developing in the organisation where I worked at the time, and despite entering into a career where roles and routines were established over many decades, I had the opportunity to work in an inpatient admission ward where I was able to observe family therapy sessions. During this time I wondered again why some services did not appear to take account of social perspectives and other influences in the patient's life in the course of their treatment. As a result I started to develop a keen interest in working with patients in this way, which involved including and collaborating with others who had different perspectives on mental health care.

Becoming involved in a family therapy clinic in the early years of my career was both daunting and exhilarating. First I embarked on a foundation course in Narrative Therapy, then I trained in early interventions for families consisting of a person with psychosis, which was a foundation level qualification for Family Therapy. As a clinician the approaches offered through systemic theories felt like a good fit with the practices of mental health nursing and family therapy. Having completed a qualifying course as a family therapist, research took me back to my original curiosity about the impact of patient suicide, focussing particularly upon professionals, which furthered my curiosity and helped me achieve an MSc in systemic/family therapy.

1.1.2 Orienting this research project

When someone ends their life through suicide the effects reverberate across staff who have attempted to help, colleagues and family members. Researching suicide was a highly delicate and emotionally laden endeavour, which involved explorative questions, open-minded curiosity, being with others who had experienced the event and reflecting upon the subject in my own time.

However, suicide is often the end point of a complex history involving a variety of struggles and distressing events. When thinking about how to prevent suicide we therefore need to address this complexity (DoH, 2012). Whilst research into demographics and risk characteristics abound and appear to dominate policy and procedure, research into suicide from an experiential perspective is less visible. It is important to acknowledge the value of the research already existing; however, what is apparent in this literature is that the voices and perspectives of people impacted by suicides is missing. The subject poses particular issues, which I will discuss in more detail. Clearly suicide is a distressing subject which involves wide and diverse emotions including shock and stigma. Mechanisms to protect and support people that may be vulnerable have been considered. I have at all times attempted to gather robust information using rigorous procedures in order to improve our understanding of this phenomenon, which in turn will inform the way services provide help.

According to Moore et al:

“There is no evidence that bereaved participants are hurt by asking them to participate in research and by allowing them to make informed consent to participate. Some participants may altruistically think they are in fact helping other survivors by participating” (2013, p. 302)

Contributors’ anxieties about assisting my research in this subject have been considered with the view that as long as the research is grounded in the ethical principles of human subject protection, ethical boards should not dictate the science (Moore et al., 2013). Having previously undertaken qualitative research into the impact of patient suicide upon professionals, I asked myself why I had returned to this subject. Is it possible that by researching suicide there is something that I am trying to transact? Self-reflexivity (Finlay, 2002) is woven throughout this dissertation which adds a further dimension to the multiple perspectives on suicide, suicide research and working with people who may be suicidal.

1.1.3 Taking a position on the subject of suicide

As part of the preparation for undertaking this research I was invited by my supervisor to consider the subject of suicide and the variety of views and positions that I might take. This led me to reflect upon the subject of suicide in relation to different contexts, which can be thought of as different positioning's, as follows:

1. Suicide as an 'escape' when people become physically unwell.

In the context of diminishing mobility and limitations /constraints that failing health might bring, as is often associated with physical and psychological illness, and the need to rely on others to do the day-to-day things in life. Complicated challenges are posed to individuals and families, who are providing care through trying to encourage and support their unwell relative whilst also living their own lives. What sense might one make of the continual pursuit of life? Certainly consideration of the quality of life versus the quantity is sometimes made within the context of constant struggle, pain and suffering. Alongside the thought of it all ending, or bringing an end to it all, liberation from the failing shell within which one resides, may indeed seem a worthwhile position to take, one that many people would understand and empathise with.

Speaking from the position of one of the daughters of parents who both experienced painful and agonising illness at the end of their lives, it was striking how differences in outlooks remained. For one parent who wanted very much to live and felt they had much left to do in life, the fact that death came too soon left a sense of feeling cheated. Alternatively, for the other parent, death could not come soon enough and their requests for the doctor to hasten the end came fast and furious. This left me feeling real compassion and empathy for people, with the twists and turns of life and where that takes us. Nothing in life, apart from death, is certain.

2. Suicide as a 'relief' when caring for a person who has physical or mental illness.

People caring for someone with physical or mental illness day in and day out, may be on the brink of thinking about a time when they are free of the responsibilities involved in the caring role. The struggle of caring for one or

more dependents may become too much to bear. Tiredness and lack of support in ones own right, with all the emotions therein, may lead to a sense of hopelessness whereby either suicide or some other event to punctuate the struggle becomes an eagerly awaited relief that is rarely spoken of out loud.

I remember the wife of a person with mental illness I was involved in caring for. She expressed frank irritation with her husband's illness, seeming to have limited patience with him and the ways that the illness had both affected him and their lives together. She expressed exhaustion and frustration about the way life was, caring for their small child, her husband had lost his job, they had financial problems, etc. She met the numerous overdoses that he took with what seemed increasing annoyance, remarked he was "crying wolf" and seemed devoid of sympathy or compassion, so much so that she actually said she wished him dead. This was shortly followed by his suicide.

Whilst I do not know how this left her, I can but wonder how his death might be explained to others, including their child, and how his existence in their lives would be remembered?

3. Suicide as 'giving up' when living with mental illness.

When a person is mentally unwell, it is relatively common that ones own death or suicide is thought about from time to time. It is possible to gain a sense of how this might affect a person who is unwell and I wonder who has not thought, even fleetingly, about the option of suicide in moments when life feels a real struggle? From working with people in this situation over many years I have found it most useful to acknowledge this point of view held by the person, not disputing or arguing about it, but aiming to accept their point of view. Inviting them to think however about alternative options whilst also holding on to their point of view, and entering into conversation whilst acknowledging their view, seems both respectful, empathetic and not oppressive. Engendering realistic hope and striking a balance however is precarious and can easily lead to the person feeling misunderstood and patronised.

I recall talking with a person recently that I have known professionally for many years, whom over this time has tried virtually everything to end her life and continues to have such thoughts now, twenty years on. She speaks of the struggle between living and dying, wishing on occasions that she did not have

children and grand children, then she “could just go”. Or indeed by placing herself in high risk situations whereby her death is expedited by someone or something else.

Being able to have conversations like this I feel gives credence to discussions with people about life and death and what living dying might actually mean to them. By being with the person, almost alongside and bearing witness to the struggle between living and dying, whilst incredibly demanding, is an important part of what can be done and in some way keeps channels of communication open.

4. Suicide as a position from the ‘ethical / professional’ viewpoint.

Speaking from my position as a person who has worked for over forty years in the NHS, I can only imagine the darkest places that people enter into, who then move on to take their own lives. Somehow, it is possible to feel a sense of relief on their behalf, once an end to the suffering has come. No one really knows what happens thereafter and no one is in a position to judge what is right and wrong. Certainly, if faced with continued pain and suffering myself, I am of the view that bringing an end to the suffering myself is not beyond the realms of possibility. However having researched the ethics around suicide, this is a position that one has to take very seriously as assisting a person in the act of suicide is a criminal offence.

Whilst it is sometimes very natural to see and try to understand a person's point of view about not wanting to continue with life, the position as a professional working in the National Health Service, has to be one of understanding, compassion, empathy and engendering realistic hope. This position is non negotiable and is part and parcel of the territory.

5. Suicide from the position of being a human being making an informed ‘choice’.

Suicide was decriminalised in the 1960's which is still relatively recent and within my lifetime. Up until then, people attempting to end their life were scorned and could be subject to criminal proceedings. People that ended their lives often being buried afterwards in non consecrated ground.

Changes in law and more generally within society mean that people can nowadays travel abroad and end their lives through euthanasia, if they so wish. Much debate continues about the right and wrong of such liberty however there is no denying that for some people euthanasia or death by ones own hand and design, is taking place on a regular basis without retribution or risk of prosecution. The important distinction to make here is one of the individual being in possession of mental competence, which if indeed is the case, cannot be refuted.

Reflecting upon these varied and often polarised positions leads me to wonder about the continual dilemmas faced by people day after day, for example;
The people that desperately want to live who are dying and
The people that do not wish to live that are desperately wanting (and perhaps trying) to die. Ultimately there is little sense to be made of such a dilemma in life or in death. Indeed, working in the field of mental health and undertaking this research posed real challenges, with the necessity to navigate between different positions in order to be able to coordinate, or 'attune', with people telling their stories, the family members and staff who had a great deal to say.

1.2 Guidance for the reader

I begin with an introduction in Chapter 1. The research literature is reviewed in Chapter 2, firstly considering the wider context in which this research took place, including some reflections from my personal and professional experiences in family/systemic psychotherapy, before a review of the literature about suicide. The influences upon this research and the parallels drawn between this, my development and epistemological stance, follow next. I present the methodology in Chapter 3. In Chapter 4 the method and design are discussed, including data collection methods and an outline of the rationale for the method of information collection. In addition Chapter 4 sets out the sampling strategy and selection criteria. I had several in depth discussions with colleagues about patient suicide and family members affected by suicide, which informed my decisions and choices. In Chapter 5 I present my analysis where a summary of the main findings can be found. In Chapter 6 there is a discussion of the findings and recommendations. Finally I conclude the research in Chapter 7.

2. Literature review

2.1 Introduction

To begin with, it is important to highlight that suicide and suicidal behaviour can evoke strong emotions. Wide-ranging opinions and viewpoints about suicide and suicidality abound. Acknowledging the emotional impact of suicide from the start of this thesis is critical, as it forms so much of the content under discussion, especially in terms of those directly affected such as family, relatives and friends, but also the community at large and staff including therapists. I am very familiar with the subject and territory of self-harm, suicidal thinking, suicide and risk, which has formed part of my clinical practice each and every day. However, my experience and the necessity to write objectively about this subject may lead the reader to think I am being clinical and factual. For people who are not so familiar with the subject it is important to take a moment to think about the impact it may have before entering this landscape.

Efforts to be sensitive and respectful have been made and attended to wherever possible; however, the business of construction, deconstruction and talking about this research needs to take place. My sincere hope is that I do so without causing offence. Self-harm and suicide can be offensive, even brutal at times. Therein lies a dilemma and a delicate balance needs to be struck. Not talking about suicide feeds a self-perpetuating cycle of taboo, silence and fear.

This chapter is divided into sections:

- Some definitions of suicide
- Personal reflections on working with people who are suicidal, my personal story and background
- The context in which this research took place, including the policy and processes within the National Health Service (NHS)
- A review of the literature, including the language of emotion and relational discourse, Family Therapy research, the impact of suicide upon staff and families

- Research into the experience of families after suicide, which provides a large part of the rationale for this study

2.1.1 Some definitions of suicide

The Oxford Dictionary defines suicide as:

“The action of killing oneself intentionally” (Oxford English Dictionary, 2015)

Suicide is a course of action that is disastrously damaging to oneself or one’s own interests. It is said to originate from the Latin: *sui* ‘of oneself’ and *caedere* ‘kill’. Language used to describe suicide has clearly moved on since Roman times, with Marsh (2010) proposing the description:

“Self accomplished death” (Marsh 2010, p. 219).

Suicide was regarded a sin until 1961, when the Suicide Act (1961) was passed through parliament. After 1961 anyone who failed in the attempt to kill themselves would not be prosecuted. The use of the word; “commit” before suicide implies a particular criminal meaning vested in times past, nonetheless this term has remained. Language and use of words is discussed later, however I raise this to highlight their importance.

2.1.2 Background and wider context of this study

This section aims to set the context and background in which this research has been carried out, including NHS policies relating to suicide prevention and my personal/professional experiences and reflections. Whilst this consists largely of literature and policy about the mental health professions and statutory organisations, it in no way is intended to privilege this above other literature but merely serves to illustrate the relative paucity of research into service user and family experiences of suicide.

2.1.3 Reflections of working with people who may be suicidal

Working with people who may be suicidal has been a part of my professional life for many years. The emotional and psychological impact can be immense. To illustrate this I would like to mention the research I undertook previously (Bird, 2009).

I was working with a person in a community mental health setting, who for the purposes of this publication I will call Ann. Ann had attempted to end her life at the age of 30 and continued to experience suicidal thoughts in the context of a number of other significant losses. Within the therapeutic alliance and relationship that developed between us, conversations took place whereby Ann discussed her inner thoughts, feelings and vulnerabilities. The words related between us had a quality that felt valuable and substantial. However I can clearly recall, as though it were yesterday, the sense of apprehension I felt when walking up the pathway to Ann's house, wondering whether this would be the day I discovered that she had ended her life. As time passed Ann seemed to improve. There was an appropriate step down in her care, I withdrew and another worker became involved.

Some months later I learned that Ann, despite having a young child, had ended her life in a planned and violent way on an inpatient mental health ward. Whilst this was a shock it was no surprise, as I had listened to Ann talk about having very seriously contemplated and attempted suicide over a considerable period of time. It is not possible for me to know what Ann truly experienced in that time on the ward, and the suffering and distress that may have eventually led her to take this action. In spite of having worked hard to understand Ann to this day I still wonder whether there was something else I could have done to make a difference to her life. Ann is not forgotten, nor are any of the other people with whom I have worked who then ended their lives. Some of my reflections on Ann's death are included later. This poses complex questions about the experience of the relationship between mental health staff and families after suicide and the implications for mental health services.

As indicated in the title, this research attempts to examine the experience of relational issues between families, carers and staff providing mental health services. It goes without saying that this endeavour has explored and deconstructed many areas including the emotions involved in death, dying and suicide. Family and systemic therapy takes the position that there is no universal experience of emotion understood by all cultures. To orientate the reader and prepare to set the context, I would like to summarise systemic psychotherapy and consider the contribution that it has made to this field throughout the years.

2.2 Family and Systemic Psychotherapy

You will find in the next section an attempt to summarise what is meant by the word 'family', the family as a 'system' and the body of work known as family/systemic psychotherapy.

2.2.1 What is a 'Family'?

Over recent years there have been vast changes in what constitutes a family.

"In Western countries, for example in the United Kingdom, over 40% of new marriages end in divorce with many people choosing not to marry and increasing variations of partnering, such as single parent and homosexual families" (Dallos & Draper, 2000, p. 6)

The evolution of the 'family' has meant that there is a greater diversity of expectation by people in life with perhaps both men and women sharing roles and tasks which once would have been separate. This reflects the way society is influenced by discourses and ideologies at a particular point in time (Dallos & Draper, 2000). To summarise what a family might be, the metaphor of a 'deck of cards' is useful. The family will have a unique set of cards derived from a variety of experiences including; biology, family traditions and societal discourses, etc. not solely down to choice. Indeed the way family members relate to one another within the family and participate in relationships generally is thought to be influenced by early experiences within one's family of origin. Throughout the process of growing up, informed choices are made about ways of relating with others. However, as Dallos & Draper add:

"accounts from families and therapists capture two aspects of family life which seem contradictory in that individuals seem to make autonomous decisions about their lives whilst also living lives characterised by repetitive, predictable patterns of actions" (2000, p. 8)

The difficulties that families encounter in the course of life are often those which bring them to seek assistance from helping services which might include systemic practitioners and family therapists.

2.2.2 The family as a system

Building on 'cybernetics' (Wiener, 1950) which refers to the structure and flow of information processing systems, von Bertalanffy (1969) conceived of 'general systems theory' and labelled the processes by which complex arrangements of

component parts and interacting elements combined to form interdependent entities, otherwise known as systems. General systems theory describes the structural aspects of a system, including the notion that interdependent entities or systems are composed of interrelated parts, known as subsystems. These component parts constitute an ordered whole with each part of the system impacting upon the other parts as well as the system as a whole.

Cybernetics provides a description of the functioning of a system whereby qualities of self organisation, direction, regulation and governance via a process of feedback loops through which a sense of equilibrium or stability, otherwise known as homeostasis, can be established and maintained. Using systems theory to think about families and family dynamics takes us away from a linear perspective of processes. Indeed when embarking upon this research the challenge of trying to refrain from seeing things in a linear way became quickly evident. These early theories were vital in establishing the foundations of family therapy.

2.3 An introduction to Family Therapy

Family Therapy as a distinct approach and method of psychotherapy emerged in the early 1960s. In 2000 Dallos & Draper published, 'An introduction to Family Therapy' which usefully chronicles the development and evolution of this discipline. Nonetheless, they warn that:

"The richness of the field can often be perplexing to novices, experienced practitioners and teachers alike" (2000, p. xiii)

In the forward, Vetere underlines:

"it is no mean feat to write an introductory text that is thoughtful, far reaching, informative and accurate for newcomers to a field that is rich and diverse, fast changing and sometimes riven by partisan dispute" (2000, p. xv).

Put simply, family therapy and systemic practice is a form of psychotherapy that engages and works alongside families to explore and to promote greater well-being and/or understanding (Association of Family Therapy, 2015). Thus the main aim is to understand relationships and ways of interacting throughout the life cycle of the family and its members, which can include births, deaths, illnesses, divorce, adoption, suicide and many other things. The approach and techniques utilised by family therapists and systemic practitioners are as wide-

ranging and diverse as the families that seek help. The overriding philosophy is summarised below:

“[family therapists/systemic practitioners] have in common an understanding that symptoms, problems and difficulties arise in the context of relationships, and are to be understood in terms of interactive and systemic processes. The main focus of intervention emerges from these patterns of interaction and the meanings given to them. Given this focus, the members may work with individuals, couples, families or parts of them, and other significant relationship networks.” (AFT, 2015)

The code which oversees family therapy/systemic psychotherapy practice rigorously promotes the welfare of families and individuals and the importance of therapeutic relationships being based on honesty and integrity. Therefore when faced with an ethical dilemma the course of action which ‘maximises the good’ and does the ‘least harm’ should be adopted with particular weight attached to the rights of the vulnerable and those with least power (AFT, 2015).

Dallos & Draper refer to the ‘First Order’ (2000) of family therapists, their development of structural family therapy consisting of clear family boundaries, subsystems and a positivist directive stance within the medical model which focussed on an undesired or obvious problem/symptom and prescribed steps to eradicate or reduce the effects of the unwanted problem. This approach was predicated on the view that the expert knew best, as usefully described by White (1997, p. 11):

“When a person enters the culture of the professional disciplines they are confronted with a shift in what counts as knowledge.”

White and others suggested that formal and highly specialised professional organisations, that constitute systems and cultures, are privileged and have access to objective truth. However, this marginalised more local discourses. Other ways of knowing, generated in communities and contexts of the person’s daily life, did not count or have legitimate value.

Following this first phase, the ‘Second Order’ (2000) moved away from viewing things in positivist ways towards the idea of inclusion, meaning making and working with the family to see things from different perspectives, through use of techniques including positive connotation, instead of the health/illness paradigm.

For example after a family member dies a structural void is created, therefore:

“The bereaved person or persons are viewed in the context of the family system and the family system is viewed in the context of family-community-world system” (Bowlby-West, 1983, p. 279).

Adjustments made to the void created after death were felt to be partly determined by the perceptions of family members and their cultural and psychosocial origins. It was understood that previous experiences of death impacted on people experiencing death in generations that followed. According to Bowlby (1980) to protect others, including children in the family, parents may avoid discussing their emotions because they do not want their children to experience more pain. This shows how inclusion of knowledge from perspectives other than experts was acknowledged. It may seem like I am stating the obvious, but it is important to emphasise how the experience is constructed, as it appears the way individuals and families learn about death and dying in their family influences and determines how they go on to negotiate death and dying themselves. Bereavement literature speaks about the ‘normal’ phases, or stages of the grief process, however the term ‘normal’ is used advisedly and with caution in this work, as it would all too easily confer a kind of legitimisation on the idea that this experience can be compartmentalised. Nonetheless, Bowlby-West (1983) offered useful insights that build on existing theories about death and adaptation to loss in a family system;

“Whilst they have loss in common, family members will be affected by the death of a relative in various ways at different times throughout the process of grief, dependent on how they experienced death before” (Bowlby-West, 1983, p. 284)

In any given situation or as a response to disruptive influences that might alter usual functioning, there is an inclination within systems to maintain internal stability that coordinate parts of the system in synchrony. The system that works well for all of the sum components would be one that strives for equilibrium when tension is reduced or absent. A useful analogy to demonstrate mutual behaviour is that of a colony of bees, as when they coordinate the fanning of their wings to cool the hive. This process is referred to as ‘homeostasis’. When a change occurs in a system homeostasis may be disrupted.

When referring to the family as a system, it is important to emphasise, as with any system, the inherent tendency towards homeostasis. Bowlby-West suggests that there are at least twelve common homeostatic adjustments families may need to navigate when attempting to overcome change and loss. Speaking from recent personal experience, having nursed and lost my father to cancer during this research, and recently losing my beloved 17 year old dog, I was struck that the themes summarised below can provide a sense of structure which, depending on the person, may be 'dipped' into and borne in mind.

- Anniversary reaction, which includes the anniversary of the death, birthday of the deceased etc.
- Displacement feelings which may manifest through 'bottling up' grief, with projection of anger, guilt and blame onto doctors, nurses and care staff as well as other family members. Feelings of shame and embarrassment, which are particularly common where the death is a suicide
- Enmeshment, through increased closeness, which might come about through efforts to protect against the fear and threat of more loss, sometimes resulting in lack of privacy or space
- Family secrets might develop through fear of becoming more upset or a sense of failure and shame, therefore a reluctance to 'talk about it'
- A generation gap, whereby the extended family, for example grandparents, may need to grieve more openly. However bereaved parents may not be able to gain support from other generations. According to Bowlby-West (1983), death of a child may impact at least three generations
- Idealisation of the deceased person, with family members unable to let go
- Infantilisation, where the infantile behaviour of a child may be reinforced after a death in a family, especially a sibling; or a sibling may be infantilised by another sibling who takes the role of surrogate mother or father
- Obsessive paranoia and excessive focus on the experience of the death, dwelling on the negative, bizarre or ghoulish aspects
- Pathology through expression of physical symptoms, sometimes like those experienced by the deceased prior to their death
- Replacement through substitution of the person lost

- Restructuring and role changes which might mean that siblings take on a parental role to help grieving parents. Cross-generational alliances may increase, whereby a parent may attempt to get their needs met in child-parent relationships
- Transgenerational mourning may result when previous memories of grief are triggered

Each theme is important and has relevance, taking transgenerational mourning, for example, in the instance of informal and professional caregivers who may re-experience personal losses through the loss of someone they have worked with. Through the act of helping others with grief, previous grief may be brought into the present, which may be therapeutic or traumatic to the care giver, and even reported as 'burnout'. This is important in the context of the NHS. Caring for and supporting staff in their work, particularly in relation to suicide and the aftermath, will be further considered in the literature review.

I have included the above to provide a flavour of how, over time, the orientation of Family Therapy shifted away from linear causality and interventions, as in the 'First Order', towards a more collaborative stance involving working with families. Then there was the third phase of Family Therapy, from the mid 1980s, which moved towards social constructionist theories. Social constructionism shares with systemic theory an emphasis upon the centrality of relationships in the way reality is constructed. Within this broad heading, concepts such as solution-focussed therapy, culture, context, close collaboration with families and reflective team processes were considered. Over time there was a conscious move away from the idea of there being an 'expert' position to a more egalitarian 'not knowing' position (Anderson & Goolishian, 1988). Within this approach, as an alternative to the classical view of working with people struggling with grief White (1988) talks about; *'the re-incorporation of the lost relationship in the resolution of grief'*; which challenges the idea of working with grief by assisting the person to go through stages. White (1997) argued that further work along the lines of the well-established 'grief map' of previous approaches were counterproductive, urging developments that could be more usefully and respectfully undertaken through exploring 'saying hullo again' conversations, weaving in elements of culture and context then claiming back of oneself in the light of these problems and challenges.

2.3.1 Multiple contexts, cultures and diversity as part of Family Therapy

In any situation issues of social difference are present. These may vary from being: visible and voiced; visible and unvoiced; invisible and voiced; invisible and unvoiced, and everything in between (Burnham et al., 2008; Burnham in Krause, 2012). Furthermore, the importance of 'situatedness' or 'meaning making' through multiple perspectives where all voices are heard has strengthened. All issues of social difference are important in the co-creation of contexts for therapy and learning. Krause (2012) states that culture and race are conceptual processes therefore what matters most is how we understand and what we do with such processes. What seems like recognition to one may seem like domination or subjugation to another.

"All practitioners, by dint of their own experience, skills and preferred ways of practising will have their 'favourite' issue/s to explore that are within their 'comfort zone'" (Burnham et al., 2008. p. 1).

Each one of us will find certain issues outside our 'comfort zone' and experience 'blind spots' which may inadvertently tend towards some areas of subjugation in clinical practice. I make mention of the 'Social GRRACCEESS'¹, originally conceived in the 1990s, to assist practitioners in being mindful about a vast array of difference within the 'human condition'. Whilst this list offers clarity, more recent developments embrace the complexity involved in working with individuals and families as they live their lives. This acronym also 'stands for' a position that asserts these aspects of experience as important, interrelated and constitutive of a person's experience in all aspects of their life, and therefore is important for all participants in therapy, training and supervision. As such,

"Social GRRACCEESS' may be usefully visualized as a tapestry or kaleidoscope in which the constituent parts will wax and wane in any person's practice" (Burnham et al., 2008, p. 530).

Systemic practice is flexible, and incorporates many influences. As Frosh (2013, p. 7) says,

"The systemic model has the flexibility to twist and turn ideas around to make them fit every context".

¹ Gender, Race, Religion, Age, Ability, Class, Culture, Ethnicity, Education, Sexuality, Spirituality (Burnham et al. 2008)

Furthermore Bond states that,

“A systemic approach pays attention to the contexts that give meaning to our relationships and behaviour” (2007, p. 291).

Next I will include some of the theories of family/systemic psychotherapy, after I consider the language of emotion, which is crucial to this study.

2.4 Theories of emotion

In this section emotion is briefly considered from ancient times to the present day.

Early conceptualisations of emotion were guided by mechanistic and reductive models, which proposed that emotion was merely a state of arousal or activation which compelled biologically determined survival related responses (Fontaine & Diamond, 1994) which provided solutions to ancient and recurring problems faced by our ancestors (Ekman, 1992).

The evolution and history of theory development related to emotion stretches back centuries and emanates from a variety of sources. Emotion can be conceptualised as either a stimulus, an intervening variable or response, therefore as with many other complex concepts, there is no universal definition of the term ‘emotion’ and it is virtually impossible to identify a single definition. However the most common approach to attempt definition has been to refer to an emotion as a response and as such attempt to focus upon measurable psychological, social or physiological factors.

In the 1880’s William James and Carl Lange proposed feelings and emotions as being secondary to physiological phenomena and argued that stimuli triggered activity in the autonomic nervous system which in turn produced an emotional experience in the brain. This became known as the James-Lange theory, (James, 1884) which asserts bodily responses rather than cognitive attributions, or appraisal, are the foundation to emotion. However debate continued about which comes first; the arousal driven somatic experience or the cognitive appraisal.

Appraisal based theories originated from scientific experiments by Lazarus, (1966) to study the influence of cognitive processes upon psychological stress by measuring heart rate, galvanic skin response and subjective reports by

research participants. This was undertaken when the participants watched films depicting upsetting events and were instructed to either detach from or engage from the film content. The results revealed reduced stress for those asked to detach and higher stress in those who were engaged with the content. Similarly Ekman et al, (1983) investigated the correspondence between emotional specificity and autonomic differences and found that heart rate and finger temperature increased more with anger than happiness. However this approach tended to view emotion as static, not taking account of other factors. To address the fluidity and dynamism of emotion Lazarus set out a process oriented approach, which encompassed the multi causal nature of emotion including theories about specificity and relational meaning principles, which according to Fontaine & Diamond, (1994, p142) suggest that;

“Human emotion is best thought of not only as a unitary static response, but also as a process of interacting systems whose confluence produces given emotion.”

Essentially this proposed that individual emotions may be understood within particular patterns of appraisal and that each emotion is defined by a unique and specific relationship between person and environment, which is characterized by how the events are appraised and is dependent upon their relevance to wellbeing. Hence emotion is seen as a reaction to individual and personal meaning, which is generated by appraisal.

Whilst emotion may be understood to be a relatively brief conscious experience characterized by intense mental activity accompanied with a degree of pleasure or displeasure (Cabanac, 2002), emotion and emotional states are not typically clear and distinct, more likely to be dynamic and mutable and may alter according to the social context within which they occur.

As Smith, (1989) notes; theory about emotion specific physiological activity is consistent with appraisal theories as they propose emotions are systematically organized on the basis of a particular pattern of appraisals that emerge during a given encounter.

After his mother became mentally ill and ended her life through suicide, Ekman, (1992) spent his life helping people with mental illness by researching what may

help and seeking to better understand the human condition. Whilst initially researching non verbal communication, facial expression and meaning created by movements of facial muscles, Ekman researched emotion extensively. Research findings proposed there are common characteristics found in emotions with universal themes that reflect our evolutionary history, which are recognizable across cultures and continents. Emotions such as fear, anger, disgust, contempt, sadness and enjoyment have been shown through research to have a universal span. Indeed Ekman asserts individuals experience the same emotions, however will do so differently in unique ways, which are dependent upon a variety of things including context and circumstance.

Various theories over time have added to the growing body of knowledge relating to emotion, more recently the contribution to the rapidly expanding field is that of Neuroscience, which is striving to better understand the biological basis of emotional processing and the role of emotion during cognitive appraisal and processing. By studying the brain through increasingly sophisticated methods and mechanisms including magnetic resonance imaging (MRI), more information and knowledge is amassing about, for example; perception, attention, memory and decision making, (Deak, 2011).

Results from this research are fascinating and highly relevant, which needs to be borne in mind when considering emotion from a variety of propositions including the systemic perspective.

Essentially systemic theory focuses on and relates to the communicative aspects of emotion. Consequently there is the sense that emotion is most usefully understood alongside biological determinants, as multi faceted; which, as such enshrines the values of diversity, inclusivity, tolerance of difference and uncertainty.

Taking these elements in combination and working collaboratively with medicine and neuroscience, helped me to think more usefully about my position. Whilst not wishing to be entirely organized by biomedicine within this research endeavor, it was important to recognize that 'emotion' is a product of many elemental parts, much like systemic theory, which all together provided a good fit and contributed to this research.

2.4.1 Language of emotion

To assume that a common language of emotion exists that accurately transfers meaning and experiences between people (Fredman, 1997) or,

“One emotion ‘world view’ is superior to another” (Fredman, 2004, p. 3)

that limits our understanding of this subject. Fredman offers useful insights into the language of emotion, or emotion discourse, which are relevant to working with people in a therapeutic context:

“Emotion discourse might include ideas about the nature of emotions, where they are located and generated” (2004, p. 12).

Fredman suggests emotion may be construed as something like a ‘driving force’, ‘feminine weakness’, a lack of emotion as a ‘stiff upper lip’, a ‘bulldog’ mentality, seen to originate from ‘within’ a person, created between persons or come from elsewhere outside the individual. Social constructionist approaches invite us to question not only our conscious beliefs but also our implicit assumptions or ‘common sense’. This is particularly relevant to a discussion about emotion and feelings because talk about feeling pervades much of our social interaction as well as our private internal dialogues. According to Dallos & Draper,

“It is possible that much of the time we are unaware of some of the dominant assumptions that shape talk and beliefs about emotion” (2000, p. 143).

To illustrate alternative views of first order family therapy moving towards third wave theories, I include this perspective from Shotter (2015, p. 138) who cautions against:

“The atomised world image that misleads us into thinking of all our activities as being shaped or structured by their causes”.

Instead he proposed the need for:

“A set of exemplary experiences that will provide us with a structure of anticipations as to what to expect will result from our action within our living, responsive relations to our surroundings”.

This very much parallels what I will describe later in the process of data collection, analysis and the discussion of the findings; essentially, the dilemma of presenting a dynamic systemic research study through linear representation.

2.4.2 Emotion discourse

Stories about emotion are what people weave from an amalgam of physical sensations, identities, displays and judgements within the context of their relationships and cultures (Fredman, 2004). Theories from social construction (Berger & Luckman, 1966; Burr, 1995) acknowledged that conversation and meaning are co-constructed. Fredman differentiates between two approaches to the discourse of emotion.

- **Autonomous emotion discourse**

An autonomous approach locates emotion within the individual, resulting in the view that emotion is subjective, innate, universal, personal and located in the body. Fredman goes on to say that this may lead to a focus on sensations, a distinction from identification, naming, interpreting and encouraging the expression of emotion. It may be seen that this parallels the bio-medical model.

- **Relational emotion discourse**

Relational discourse approaches emotion as created and co-constructed by persons within a community connected with cultural logic. Stories or accounts of emotion are created in the context of relationships imbued with cultural influences. Therefore different discourses inform how we experience our feelings and how we act and interact with others.

2.4.3 A relational emotion discourse

A relational emotion discourse offers distinct parallels with systemic practice, whereby systemic practitioners intend to enter into conversations with people which closely follow their feedback, generating multiple views and possibilities in an attempt to explore their preferred views and theories as opposed to providing advice and interpretations informed by one's own preferred theories, opinions or beliefs (Fredman, 2004). Thus, the language of emotion and beliefs inform the questions systemic practitioners ask and emotion talk is co-constructed, which then influences patterns of relating. Fredman (2004, p. 112) challenges the autonomous view of emotion as understood to originate from the

body of the individual, instead preferring the perspective of a relational view, whereby emotion is proffered within stories combining physical sensations, displays and individual judgements. Acknowledgement of the relevance of emotion in discourse links with ideas of 'attunement'. Shotter invites us to:

"turn away from the self-contained individual, but also away from the idea that the world in which we live consists for us merely in the earth beneath our feet –furnished with all kinds of 'separate' things along with a whole host of other, individual human beings – as well as the sky above our head. Instead the flowing, dynamic nature of our relations to our particular surroundings comes to take on much greater importance than we have ever given them before – thoughts of fixed or static forms must be given up completely" (Shotter, 2015 p. 138)

Thinking about how language is used is particularly important to this study because meaning can be conferred over time, culture and context. This will be returned to later, bearing in mind Ness & Strong (2014, p. 83):

"Sometimes unintended words and meanings can become anchored and extended in the 'taken for granted' or seemingly non-negotiable relational interaction".

This also links to relational approaches to mental illness and specifically depression. Research by Jones & Asen (2000) showed that whilst depression is personally experienced, it is largely relational and affects the person in their context, which is an area I will return to later.

2.4.4 Theories about death, dying, grief and mourning

At this point I would like to mention seminal works by John Bowlby, Elizabeth Kubler-Ross, Colin Murray Parkes and others who have contributed a great deal to this area of study. This very much influences recent theories, for example the narrative discourse of 'saying hullo' and 'remembering' (White, 1988; 1997; Weingarten, 1991) which open up space for reflection. Indeed through exploring hope and despair when working with families, particularly when negotiating loss and change (Flaskas, 2007) and talking about death and transforming emotion (Fredman, 1997; 2004) possibilities are created which look at multiple perspectives in families. These links are discussed next.

2.4.5 Bringing together thoughts about family, suicide, emotion and the research

The act of suicide and the impact afterwards evokes a wide variety of emotion. Included above are some theories that offer suggestions about how emotion

originates and may therefore be understood, which might help the reader consider and reflect on emotion throughout this thesis. The business of being with and dealing with emotion is rarely neat and tidy, often challenging. Fredman, and others, offer ways to develop understanding and insights, which will be revisited later. I make mention of these theories to illustrate how the evolution of family therapy and other theories throughout time has moved away from positivist scientific approach and how this research, being both an experiential and phenomenological study, is connected to these theories, most particularly social constructionism.

The position White (1997) takes when he talks of 'knowledge' and 'knowing' generated in communities and the context of a person's daily life resonated for me, as this research was undertaken in the NHS in a culture of professional disciplines and medical domination of 'taken for granted knowledge'. Indeed, when considering professional disciplines and professional conduct, there is an overriding expectation that the 'membership' or significant relationships within the system that is the NHS, will consist of others who have succeeded in meeting eligibility criteria and formal requirement to practice. Therefore the system and culture establishes powerful restrictions on who might participate in these systems/cultures.

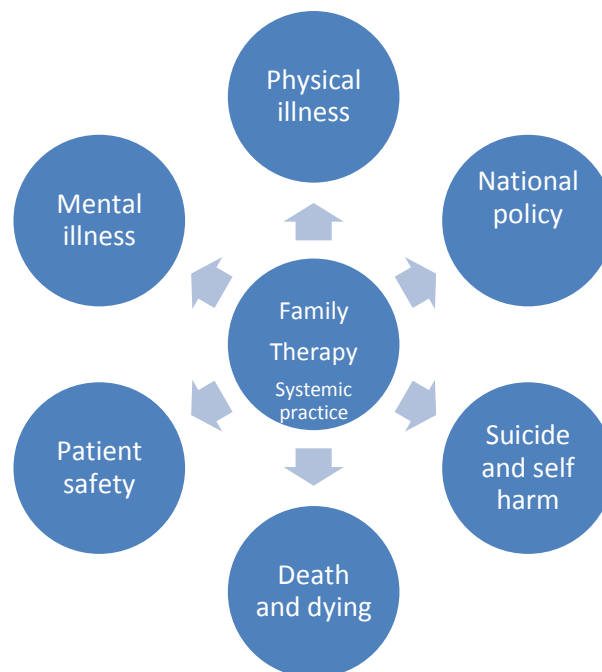
On one hand this serves to regulate practice and care by staff who are complying with the expectation of academic and other achievements, thereby protecting the public and provide evidence-based practice. On the other hand, as evident above, systems of professional disciplines can consciously or unconsciously constrain and even exclude those with less formal knowledge and impose a professional monoculture. This culture may be on the 'wane'; however it sums up the dilemma of working within a system with certain well-established professional values and traditions. For example taking a social constructionist approach in a medically dominated culture may create tension. I am not asserting that issues of culture and context, as highlighted for example by Burnham et al., (2008) and others are 'sorted', more that it is about constantly attending to, being aware and inquiring about these issues as part of every day practice in the NHS.

As mentioned earlier, family therapy and systemic psychotherapy is the theoretical and philosophical underpinning to this thesis. An integral part of systemic theory is the ability to look at things from multiple perspectives whilst

embracing curiosity. Therefore the adoption of this technique lends itself easily to approaching the task of conducting a review of literature.

Figure 1 shows I have attempted to view the background context and relevant literature through a variety of overlapping multidimensional lenses which aims to be as inclusive as possible albeit with systemic psychotherapy as a central point of departure.

Figure 1. Literature Search



2.5 Systemic thought and theory when considering death and suicide

Whilst theories and literature presented here form a platform of knowledge from which to draw, it is important to acknowledge that everyone is different. What might sound like it makes sense to one person may not fit for another, never more so than with the very complex nature of death and dying. Often influenced by what has been experienced previously, not only in the current generation but sometimes stretching back for a number of generations, Bowlby-West (1983) illustrated the impact of death upon a family system, which can manifest in a variety of ways and have far-reaching effects. What systemic theories offer are ways of working with the people in a system, with the aim of supporting them to find ways of adjusting and adapting to the loss across the life cycle that respects and promotes homeostasis.

2.6 Systemic theories on the impact of suicide happens and some personal reflections

As a nurse and family therapist, having experienced a number of patient/client suicides myself, the piece of work that particularly resonated with me was the chapter by family therapist, Pam Rycroft, in Weiner (2004), where she discusses the personal and professional impact of the suicide of a young woman with whom she had been working. It is striking that the impact she describes cross the ordinary boundaries between her professional and personal life and serve to remind us that feelings and emotions are part of being human.

After the death of my patient Ann I recall experiencing most if not all of the themes below. After each theme proposed by Rycroft (2004) are a few words in bold italics about my experience.

- *“Safety, through expression of the “feeling of working in a protected corner of my profession ... maybe other professionals had been through this many times, knew what to do, or wouldn’t have let it happen in the first place, I had been operating with a deluded sense that this couldn’t happen to me” (p. 89)*

“The sense of feeling naïve and inexperienced, ‘green’, which in my mind might have contributed to the suicide”.

- *“Despite all the support and reassurance from colleagues, nothing was able to convince me that I hadn’t failed professionally, in the most public and extreme way possible” (p. 89)*

“Doubting myself and my ability to do the job, feeling a complete failure and not worthy of being in a responsible position”.

- *“The challenge to beliefs, which Rycroft is referring to as professionally held beliefs, some consciously acknowledged, some less so. Rycroft quotes Murray-Parkes (1993) who spoke of the ‘assumptive world’, being the human tendency to assume certain things are taken as givens, which after a patient suicide challenges assumptions that may be held about the world. Therefore, “a client suicide can no longer be assumed to be something that happens to someone else and the fact that it has happened means it could happen again” (p. 89)*

“Colleagues around me seeming as though having a suicide happen was part of the job, therefore the approach being ‘shrug it off and carry on’”.

“Suicide can be felt to represent the most abject failure of the basic nature of therapy at the highest possible cost, which leads to self reproach and wondering what sort of therapist one is? “Am I toxic? Don’t let me near people at risk; they won’t be safe with me”. (p. 90)

“I recall feeling like I was incompetent, not fit to do the job”.

“It is important for a professional to be reminded that experiencing some post trauma symptoms is a sign of humanity and not weakness” (p. 91)

“Upon learning of the suicide of a patient I was working with I felt bewildered, shocked and sad for the family that found her. The child that was now without a parent, what would that mean as they grew up?”

“Personal and professional boundaries, which might for some convey the sense that the process of ‘debriefing’ can all too easily be seen as a means by which the workplace discharges any responsibility it may have to the worker” (p. 91).

“Remembering the sense of not knowing what to do, feeling exposed and vulnerable but not feeling that I had permission to reveal this”.

In her conclusions, Rycroft comments on the experience of client suicide as something that one never forgets,

“It is an experience of dread and yet I have to acknowledge some sense of relief or comfort, knowing that it is possible to survive such feelings” (p. 93)

Rycroft adds, as with any grief, that the therapist faces death as a reality and becomes mindful of the effect it may have on clinical practice, in a sense inviting the survivor to look at their own life through a different lens, bringing personal priorities into sharp focus. Indeed, systemic approaches urge adopting a culturally sensitive way that eschews widespread generalisations about mourning and assumptions about the “need to get it out” (McGoldrick, et al. 1992; White, 1988; 1997).

“Much soul searching can connect us with what is important in our own lives, with that we have to be grateful for and help develop a new appreciation and commitment to our own personal relationships” (Rycroft, 2004, p. 94)

I can certainly relate to what Rycroft says, which leads me to reflect that out of something so tragic comes the potential to learn and grow, if provided with the appropriate support and help necessary to survive the experience. I feel that the message Rycroft offers, that out of something awful good may result, is the resounding theme I wish to promote. Whilst for me the preferred approaches are those which embrace interventions intended to respect individual family members’ ways of dealing with the aftermath of tragedy, it is important to consider current fashion and trends. This brings me on to highlight the increasing tendency towards ‘commodification’ or assigning value to what might have not been previously seen as amenable to placing a cost on, for example education, health, social and medical care. The economic cost of suicide is

discussed later, however when considering the cost of treatment within the NHS, which is free at point of delivery, the digital revolution alongside development of IT and care clusters which attract tariff and budgets, introduces questions about patient choice, time and availability of resources.

2.7 Background policy and guidelines about suicide and suicide prevention

A number of policies and guidelines are included here to inform the reader about the context in which this research was undertaken. I have included these particular policies to track the development of a national strategy relating to suicide and to follow the evolution of including service users, families and carers' views and also those of the staff/personnel delivering care. By doing so I hope to show how policy and legislation has, in some ways, mirrored the evolution within family therapy and research, from taking an expert position to a more collaborative and inclusive stance.

Within the NHS commissioning and provision of services is driven by a national policy developed from an identification of need and availability of research evidence for treatments which can respond to that need. Whilst it is not within the remit of this thesis to review all of the government policy relating to suicide prevention, this study has been undertaken within an NHS mental health setting, and my ultimate desire is to improve the experience of families and people affected by suicide who have access to NHS services.

Suicide prevention has been a high priority for public health and mental health services nationally (DoH, 1999; 2002; 2009). It is vital that services improve clinical practice if suicide is to be prevented for people with mental health concerns (NPSA, 2009a.). A brief summary of some of the relevant government strategy, policy and service developments since the turn of the century, and the launch of the National Service Framework for Mental Health (DoH, 1999), have identified actions for suicide prevention and reduction, which are presented here.

2.7.1 The National Confidential Inquiry into Suicide and Homicide.

The National Confidential Inquiry into Suicide and Homicide (NCISH) has been collecting information about unexpected deaths by suicide and homicide nationally since 1996. Each year the NCISH present annual findings, including statistics, which feed into government policy and strategy. This heralded a drive

to improve Patient Safety, when the National Patient Safety Agency (NPSA) implemented toolkits for monitoring performance of standards of practice within the NHS. I discuss this more in detail later.

Within the strategy Safety First (DoH, 2001) staff training and learning from adverse events was highlighted in a formal sense with a number of recommendations made for practice which included conducting a multi-disciplinary review routinely following a suicide and minimum levels of training in suicide risk for staff. In addition routinely sharing information with families after a suicide was advocated. In 2002 the National Suicide Prevention strategy was launched in England by the Department of Health with the aim of reducing the death rate from suicide and undetermined death by at least a fifth by the year 2010 (DoH, 1999; 2002).

2.7.2 Suicide prevention and ‘Being Open’

The National Suicide Prevention Strategy annual report in 2005 reported that suicide rate was on a downward trend (NIMHE, 2006, p. 53). It recommended:

“Promotion of the mental health of those bereaved by suicide with the need for further work identified to provide timely support and information to those bereaved by suicide”.

The National Reporting and Learning Service (NLRs) launched ‘Being Open’ (NPSA, 2005) which offered guidance on communicating effectively with patients when things go wrong. This document provided a framework for best practice for all health care staff, including NHS Boards, clinicians and Patient Advisory Liaison Services (PALS) and set out principles outlining how to communicate with patients, families and carers following harm, placing open and honest communication at the heart of healthcare.

Within the ‘Being Open’ framework acknowledgement was made that being open when things go wrong can help patients and staff cope better with the effects of an incident. However, staff being fearful of upsetting the patient or family, saying something which may be wrong or admitting liability was acknowledged. Therefore reassurance was made that being open and saying ‘sorry’ is the right thing to do and NHS Boards were urged to make a public commitment to be honest, open and transparent. With audit mechanisms to measure activity locally and nationally statistics about patient suicide were rigorously collected. Good practice guidance set out basic principles that

underpinned communication between the NHS and patients/carers when an incident of serious harm or death occurs. This included the principle of acknowledgement, truthfulness and apology,

“With any contact to be undertaken in a respectful, dignified and compassionate manner and in a spirit of openness” (NPSA, 2005, p. 19).

The needs of families and carers have only been acknowledged recently (DoH, 2002 a) and this is reflected on a national level where it has been increasingly recognised that families and carers of people with mental health problems have often felt unheard and excluded. Research exploring the needs of families and carers concluded:

“They would like to be listened to, supported and to be involved with planning a relatives care ... information is required about diagnosis, treatment, services, benefits and whom to contact in an emergency ... however a cultural shift in mental health services is required if partnership working is to become a reality” (Stanbridge & Burbach, 2004; 2007).

This is relevant for families and carers consisting of a member with a wide variety of conditions, including mental health problems. When a person dies through suicide, whilst receiving mental health care, starting a partnership which involves working with a family or carer is even more important. In the report on the ‘National service framework for mental health: five years on’ (DoH, 2004) the needs of carers were clearly acknowledged and reinforced. Around the same time acknowledgement was made that the impact of suicide on family, carers and others is similar to a trauma. The National Institute for Clinical Excellence (NICE) recommended ‘watchful waiting’ for people exposed to trauma (NICE, 2005) and sets out best practice standards for treatment. Whilst experiencing grief after loss is a natural part of being human, and not necessarily characterised as trauma, suicide is different. This will be discussed in more detail later.

2.7.3 Seven Steps to Patient Safety

Seven Steps to Patient Safety in Mental Health (DoH, 2008) placed emphasis on supporting staff, involving and communicating with service users and members of the public:

- Step 1: Build a safety culture
- Step 2: Lead and support your staff

- Step 3: Integrate your risk management activity
- Step 4: Strengthen reporting in mental healthcare
- Step 5: Involve and communicate with service users and the public
- Step 6: Learn and share safety lessons
- Step 7: Implement solutions to prevent harm

In the same year, *Help is at hand* (Hawton et al., 2008), was launched, a 48 page booklet developed to respond to the needs of anyone affected by suicide. This came out in addition to the National Suicide Prevention Strategy toolkit (NPSA, 2009a) which made recommendations for action after a suicide, suggesting that a staff member should be identified as a contact point for families/carers. NHS organisations were required to submit records of compliance in combination with performance against standards. The growing impetus to quantify, measure and match performance against standards in the NHS gathered pace. In this context the revised 'Being Open' framework (NPSA, 2009b), set deadlines for action by the NHS by November 2010 regarding communication with patients, families and carers. Suicide prevention has been and remains a key national priority for the public health and mental health services (DoH, 1999; 2002b, 2009).

However, people with mental health problems are a particularly high risk group and it is vital that services improve clinical practice if suicide is to be prevented (NPSA, 2009). In *Preventing Suicide: A toolkit for mental health services* the 'Post-incident Review' (NPSA, 2009, p. 16) comments directly on the impact of a patient suicide on staff, patients, carers and families. It sets out an audit procedure for untoward incidents and a review of the support staff, family/carers and relevant others have received. This document recommends that a multi-disciplinary team review is carried out within two weeks and that all staff, patients, family/carers are given prompt and open information about support as soon as they require it. In addition, Standard 4 of the Toolkit (NPSA, 2009) specifically focusses on family/carers by inquiring whether they were notified of a serious untoward event (including suicide) by the mental health service, whether a person was designated with whom they could communicate and whether the family/carer were invited to participate in the untoward event review (NPSA, 2005; 2009). As mentioned earlier audit mechanisms are used to

measure activity nonetheless the contradictions present themselves as policy and guidance produced to improve mental health and suicide prevention appears to have been arbitrarily adopted in some patches and not in others.

2.7.4 Preventing suicide in England

The Government launched 'Preventing Suicide in England: a cross-government outcomes strategy to save lives' (DoH, 2012) which replaced the previous 2010 strategy and promoted the view that suicide prevention is not the sole responsibility of health services alone. This appeared to mark the advent of measures to increase emphasis on the collaboration between and across traditional boundaries of care. Indeed, it was acknowledged that only a quarter of people who die from suicide have been in contact with mental health services in the previous year (NCISH, 2015), therefore the strategy recommended including all services. This was an important point at which acknowledgement appeared to be made that implementing change in one area would not effect meaningful change more widely, which presents parallels with systems theory, discussed earlier.

The most recent strategy for Preventing Suicide in England (DoH, 2013) consists of the following six areas for action:

- Reduce the risk of suicide in high risk groups
- Promote mental health and wellbeing in the population as a whole
- Reduce access to the means of suicide
- Provide better support for those bereaved or affected by suicide
- Support the media in delivering sensitive approaches to suicide/suicidal behaviour
- Support research, data collection and monitoring

This clearly places the provision of better support in a much more prominent position and indeed calls for research into the subject area.

2.7.5 The National Suicide Prevention Alliance (NSPA)

The National Suicide Prevention Alliance (NSPA) was created in 2013. This is a cross-sector, England-wide coalition, supported by the Department of Health

and partner agencies, committed to reducing the number of suicides in England and improving support for those bereaved or affected by suicide. The underpinning philosophy is that every suicide is a tragedy that can be prevented. Within the NSPA Annual Review, (NSPA, 2013) a 'Call to Action' mobilised organisations from across all sectors, identifying shared priorities and highlighting key areas for action. In July 2013, on behalf of the stakeholders brought together by the Call to Action for Suicide Prevention in England, the Samaritans were awarded a grant from the Department of Health for £120,000. This marked the importance of commissioning not only statutory but also charitable organisations in the quest to reduce suicide and learn more about what helps. Contrary to quantitative aims previously proposed by other policies, the core aims of the NSPA were more about quality, including:

- *Building an active network to deliver guidance and support materials for local authorities of organisations committed to taking action to reduce suicide and improve the support of those affected by suicide*
- *Improving support by reviewing accessibility and quality of relevant information, as well as sources of support for people at risk of death by suicide, those worried about a loved one and for those bereaved by suicide; ensuring that families and carers can play a full role in improving the accessibility and quality of information, and support for those at risk of suicide and those bereaved by suicide*
- *Share best practice by enabling stakeholders to map the actions they are currently taking to reduce suicide or support those affected by suicide, and share information and examples of good practice*

2.7.6 The professional duty of candour

In June of this year 'Openness and honesty when things go wrong: The professional duty of candour' (General Medical Council (GMC) and the General Nursing Council (NMC) 2015) was published. This marked the point in time where two significant professional bodies jointly collaborated to provide guidance about the responsibility of all healthcare professionals to be honest with patients when things go wrong, described as 'the professional duty of candour'.

Figure 2 The professional duty of candour

<p>The professional duty of candour (GMC/NMC 2015)</p> <ul style="list-style-type: none">• Discuss risks before beginning treatment or providing care• In what circumstances do I need to apologise to the patient?• When should I speak to the patient or those close to them and what do I need to say?• What if people don't want to know the details?• Saying sorry• Speaking to those close to the patient

Figure 2 shows the main points within the Professional duty of candour. The resemblance to 'Being Open' (NPSA, 2005; 2009) is apparent, and leads one to wonder what happened to the guidelines launched previously, which will be discussed later.

2.7.7 Suicide prevention in the context of national guidance and legislation

The national policy presented above provides an insight into the context and setting of the NHS. Whilst the above presents a brief summary of policy, with both quantitative and qualitative aims, it seems that interventions to measure and correct, akin to the first order scientific approach through legislation, outweigh those designed to capture human experience and discourse. It remains to be seen whether the 'call for action', the publication of professional duty of candour, actually leads to change and delivers positive results within the current climate of shrinking NHS budgets.

2.8 Developments to improve the inclusion of family/carers

Running parallel to government policy developments to improve the NHS were the early shoots of work to develop carer/family inclusion, with recommendations informed by the views of carers and within Somerset, the location of this study, mental health services focused on providing and evaluating family interventions in psychosis services (Burbach & Stanbridge, 2006; Stanbridge, 2012).

The Carers Trust launched the 'Triangle of Care' in 2010, followed by a second edition in 2013, to identify ways of improving engagement and collaborative relationships between professionals and carers.

Figure 3 Triangle of care

The Triangle of Care (2nd Ed.) (Carers' Trust, 2013)

1. Carers and the essential role they play are identified at first contact or as soon as possible.
2. Staff are 'carer aware' and trained in carer engagement strategies.
3. Policy and practice protocols re: confidentiality and sharing information are in place.
4. Defined post(s) responsible for carers are in place.
5. A carer introduction to the service and staff is available with relevant range of information.
6. A range of carer support services is available.

Since inception, the Triangle of Care has evolved into an initiative that encompasses all areas of mental health service delivery across England and advocates a therapeutic alliance between service user, staff member, and carer that promotes safety, supports recovery and sustains wellbeing.

Essentially the Triangle of Care invites organisations to map services against a self-assessment framework to identify the level of engagement and inclusion of family members and create a plan of action to address areas requiring improvement. Whilst the principles behind this initiative are sound and noble, at present there is no compulsion for organisations to adopt the framework, although the hope is this will change. Indeed in the Care Quality Commission (CQC) review of half a million people's experiences of help, care and support during mental health crises (CQC, 2015) 57% felt as involved as they wanted to be in their care planning, 6% felt they were not involved at all, 23% felt they had not agreed the care they received and 32% said they were unsure who they should contact in a crisis.

2.8.1 Linking legislation and policy with this research

Policy and guidelines that have been developed towards the prevention of suicide have shown a reduction in inpatient suicides (Appleby et al., 2006); however, when there is a family history of suicide (Roy et al., 2002) little consideration of the family or wider system appears to have been made. Within this section I have included the Professional Duty of Candour (GMC; NMC 2015) and the Triangle of Care (Carers Trust 2010; 2013) because despite government policy recommendations, inclusion of and being open with patients and families appear to be sadly lacking. Indeed the voices of patients/service users and families/carers of people have long been disregarded, as discussed

previously, however change appears to be afoot. Inclusion of these voices and perspectives, to influence how services work, can only be a positive move.

2.9 Safety within the NHS

Within this section about the background context of the NHS, it is not possible to avoid mentioning three significant reports that were published in 2013.

Almost every day there is comment and reference in the press and news about the NHS, usually in the context of reducing budgets, introduction of targets which are linked to financial incentives and the push for NHS Trusts to achieve Foundation status, thereby allowing more local control over spending. What we know is that some organisations, for whatever reason, seriously compromised patient care in an attempt to 'balance the books' and the bodies that were overseeing the processes did not become aware until catastrophic harm occurred.

2.9.1 Francis, Keough and Berwick and Patient safety

The Francis Report into the Mid-Staffordshire NHS Foundation Trust (Francis 2013) exposed horrific standards of care resulting in patient deaths. The enquiry set out 290 recommendations for wide-sweeping improvements. This investigation happened in the response to a public outcry from local people in Mid-Staffordshire after concerns raised were dismissed by regulatory bodies. However Mid-Staffordshire was not the only NHS Trust which gave cause for grave concern as Sir Bruce Keough (2013) found shortly afterwards:

'Hospital boards and management teams struggled to understand and deal with the complex causes of high mortality, particularly relating to urgent and emergency care. In several cases, we identified issues that had to be tackled immediately in order to avoid causing possible harm to patients' (2013, p. 16)

Later in the year, the prime Minister asked Professor Don Berwick, an internationally renowned expert in patient safety, to carry out a review of patient safety in the NHS. Berwick found the NHS could offer the safest healthcare in the world if it took "serious and profound" action (Berwick, 2013). The Berwick report was the latest into failures in the NHS, and it highlights the main problems, recognising the necessity for wide systemic change, trust in the goodwill and intentions of the staff and abandoning blame as a tool. The report encourages staff to take pride and joy in their work, not to be afraid. Whilst advocating the primacy of working with patients and carers to achieve health

care goals, Berwick urged caution with the use of quantitative targets, with essential prioritizing of transparency.

Whilst these reviews recognised that patient safety and high quality care required the constant attention of leaders and continual support to the staff and workforce, they demonstrated that much was yet to be done towards the aim for zero harm in the NHS. The imbalance in commissioning between physical and mental health remain. Nonetheless the Crisis Care Concordat (DoH, 2014) set out recommendations for multi-agency working to help coordinate and respond to people in crisis and acknowledged that shared coordinated responses were needed to make meaningful change.

2.9.2 Measuring patient safety within the NHS

Tensions still exist within the NHS between providing high quality safe and reliable services within a culture of reduction in spending. The Care Quality Commission (CQC) identified a benchmark to assess and match compliance with safe standards of practice, essentially meaning that NHS Trusts that do not comply receive recommendations and measures for improvement with the possibility of closure, if indicated. Standards focus upon 5 domains and five Key Lines of Enquiry: Are services:

well led, responsive, caring, effective and safe?

Whilst these domains are undeniably less quantitative than previous, and move more towards measuring quality, questions remains as to whether improvement is achievable within the current climate of spending cuts. This has become apparent in the recent CQC review 'Right here, right now' (CQC, 2015) conducted into experiences of help, care and support for people during a mental health crisis. CQC concluded:

"The health and care landscape is struggling to provide appropriate levels, quality of responses and support across the system." (2015, p. 12)

2.9.3 Parity of esteem

Meanwhile, the national debate on 'parity of esteem' (Millard & Wessely ,2014) between physical and mental health has gathered momentum, with recognition that mental health problems account for 28% of national morbidity however only receive 13% of NHS expenditure. The need to 'close the gap' between mental and physical health services has been promoted. Despite Berwick calling for a culture of 'zero harm in the NHS', it has been acknowledged that 'moving

towards this quickly would be a challenge'. With NHS England recommending commissioners apply the higher tariff for mental health trusts, the question remains unanswered about how proactively mental health services can, and are, responding with new initiatives to tackle the patient safety challenge, which in turn could also serve to widen the inequality and gap between mental and physical health services.

2.9.4 The economic cost of suicide

The economic impact of suicide is considerable, although comparatively few studies have sought to quantify these costs. In a recent London School of Economics report (McDaid et al., 2011) it was estimated that the average cost per completed suicide for those of working age in England is approximately £1.67 million (2009 price calculations). However the daughter of a woman who absconded from hospital and ended her life through suicide was awarded £10,000 compensation by the High Court in 2004 for a violation of the European Convention of Human Rights, which protects the "Right to Life" (Savage v South Essex Partnership NHS Foundation Trust, 2008; 2010). This case set a legal precedent by stating that a health authority had failed in its responsibilities towards vulnerable patients. In addition to the pay award the judge ordered the NHS Trust to pay the costs of the case, which would have amounted to hundreds of thousands of pounds.

2.9.5 Risk management

Much is said and written about the management of risk in the NHS. On one hand risk exists no matter where you are. The idea that risk can be accurately measured is misleading, as risk is by definition dynamic and dependent on many variables. Attempting to measure risk in a linear way through implementing policies poses challenges due to the very nature of something which by definition is dynamic and mutable. Viewing risk in a linear positivistic style is very much taking the 'expert' stance, which counterpoints Durkheim's thinking, who argued for the importance of the role of society in suicide (Durkheim, 1951) and Isabel Menzies-Lyth's notion of the 'social system as a defence against anxiety' (Menzies-Lyth, 1959; Cooper, 2010). More recently Geldenhuys et al. (2012) acknowledged that awareness of anxiety in relation to risk management assists businesses in the way they manage risk.

2.9.6 Policy, background and the implications for this research

I have included above some of the most significant policies and reports relevant to the NHS in the last 15 years, particularly in relation to patient safety and suicide, and the dilemma of how to follow these guidelines in an NHS culture where budgets are being reduced. How the NHS adopts and implements the recommendations from the reviews included above is yet to be seen.

Reflections here about the way the policy shapes the NHS are important as it strikes me that whilst policy clearly assists in the implementation of standards and targets; I wonder whether in some cases it may also function as a protective layer for organisations.

From first hand professional experience I recall many occasions when an incident had happened and immediately attention was turned to whether or not policy had been followed. Indeed I recall times when needing to make contact with a family member after a serious incident only to find the details of next of kin were nowhere to be found. A policy is only useful if the people working with it and the managers implementing it do as intended. Another question that might be posed here is whether policy serves to create and maintain a distance between patients, families and services. From my perspective the role of policy can have a constraining effect on those working within these systems. Indeed Scott & Starr (1981) describe a 24-hour psychiatric and crisis service which grew out of family therapy research in Barnet. Whilst the paper is over thirty years old it promotes family therapy approaches to define and overcome the;

“‘Treatment barrier’, through which we must penetrate before treatment and account of relationships can begin” (1981, p. 179).

Therefore the challenge remains today, as then, of how to work in systems with constraining policies and

“Find practical ways to penetrate to the human relationships which have so often been abolished by it” (1981, p. 186).

Values that embrace the tradition of working with families and systems are as relevant today as they were then. Placing people and families at the centre of mental health services fits comfortably with systemic and family therapy practice.

Having briefly considered some of the relevant policy above, I will comment on the way policy and procedure have developed over time and the impact made upon people receiving services. Fredman presents the view that:

“psychological theories of death and grief have become ritualised by experts and turned into policy and procedures for good practice on how to deal with dying and bereavement, in order to manage the associated pain and anxiety” (1997, p. 12)

I concur with Fredman’s remark, who adds that in some situations patients, carers and families may find approaches that strictly adhere to policy and procedure undermining. Some patients and families do not want to talk to professionals about their grief. This is important and I often wonder what happens to the human voice which may be lost or silenced in the context of following procedure. The NICE guidelines offer such guidelines for treating trauma, however, as we know, what works for some, might not work for others:

“over confident pronouncements about ‘what works’ often reveal a narrow preference for linear explanations, a taste for top down managerialism, careerist scheming and currently as in the case of mental health, a readiness to tailor practice to make it ready for easy pricing and commodification” (Wren, 2015, p. 28).

2.10 Suicide statistics and the local position in Somerset

Suicide statistics compiled by the World Health Organisation (2015) estimate that 800,000 people die by suicide every year. For every suicide it is suggested that at least six family members are survivors. However due to the stigma associated with suicide (Linn-Gust, 2001; Grad, 2011) this figure may be an underestimate. Research indicates that patients with mental illness are at a greatly increased risk of suicide. Approximately 90% of those who die by suicide were found to be suffering from a psychiatric disorder at the time of death (Kapur, 2009). The suicides of inpatients on mental health wards reduced by 58% between 2001 and 2011; however statistics show there has been a 60% increase in suicides for patients under the care of crisis resolution/home treatment teams (NCISH, 2015). In England, one person takes their life every two hours. The most recent national data shows there were 4,756 suicides of people aged 15 or above in England in 2015 and the percentage per 100,000 of the population ranged between 7.2 and 11.8. Breaking this down by gender reveals there is a threefold likelihood that men will end their life through suicide compared to women, with a total of 3,674 male suicides and 1,081 female

suicides in 2013. To reduce suicide, closer working with families and carers of mental health patients was recommended. Without doubt, suicide is often the end point of distressing life events, psychosocial influences within the context of a complicated history of demographic risk factors. The emotional and economic costs are great. In 2012 the Health and Social Care Information Centre showed there were 8.5 suicides per 100,000 people aged 15 or above in Somerset. 70% of those deaths were male. Those aged between 35 and 64, both male and females, showed the highest rates. Therefore according to the South West Public Observatory (2012) Somerset is ranked fifth in the region (from low to high).

2.11 Approaches taken to research completed suicide

There is a great abundance of statistical research into suicide prevention which sets out risk factors, assessments and the demographics of people at highest risk. This has been developed over time to assist in the identification of people who may be suicidal and at risk. Information about demographics are collated nationally. Traditionally research findings have involved quantitative counting, examining demographics, themes and trends after a suicide, followed by recommendations for prevention. These are reported annually and analysed over the longer term (NCISH, 2015).

2.11.1 Measuring action against recommendations from suicide research

The quality of risk assessment prior to suicide and homicide (NCISH, 2013 a) has been researched and suggests that risk in the mental health patient population is often reported to be low or not present. Therefore a framework for evaluating the quality of risk assessment prior to suicide was piloted and used to analyse 42 cases of suicide, which found that in 36% the risk assessment was considered unsatisfactory. The key messages from this pilot study are that risk assessments need to be individual to each patient, assess current factors and past history, and include a risk management plan. Anxiety around risk assessment and management appears to be not taken into account. In addition the impact of service changes has been studied (NCISH, 2013 b). Mental health services which had introduced and implemented nine national key recommendations for changes (DH, 2001) had lower rates of suicides than services which had not.

This brings to a close the background section which has been combined with my professional reflections to present the research context to the reader, with all of the contradictions therein.

2.12 Review of the literature

Research into systemic approaches to suicide are relatively few, however Goldney (2013) suggests that much change has taken place for the better in the field of suicide prevention research over the last five years. This literature review will attempt to take account of not only more recent studies but also older studies. I will begin by outlining the approaches taken to researching suicide. This will lead to questions around the use of the psychological autopsy method and the dominant discourse. I will move on to reviewing the literature about the impact of completed suicide, firstly upon family and carer networks. This is followed by reviewing the literature into the impact of suicide upon staff and health care professionals and some of the subsequent interventions. The potential influences of conducting research with people who have experienced either the suicide of a family member or a patient is included, with attention being drawn to the specific research question posed within this study.

First I would like to consider some systemic perspectives on suicidality and how it is experienced in the family. Aldridge (1984) has explored family interaction and suicidal behaviour. He asserts that social networks consisting of family, kin neighbours and friends have a function;

“To give and receive love and affection, to be dependent and depended upon, to control others, be controlled and to provide emotional and instrumental sustenance” (Aldridge, 1984, p. 310).

However, when these supportive relationships become subject to psychosocial stressors, suicidal behaviour may result as a form of communication between vulnerable people and family networks. A number of factors are highlighted which might indicate suicidal potential within a family, particularly intra-familial conflict. More recently Roy et al. (2002) showed that a family history of suicide was linked with suicidality at all the stages of the life cycle.

Aldridge & Dallos (1986) explored these ideas by researching twenty families, ten where suicidal behaviour is present and ten where absent. This study found that in families where suicidal behaviour occurred, three variables were present:

- The threat of immediate breakup of the family relationship, for example, when someone is about to leave
- A situation of mutual negative connotation whereby no matter what anyone tries, it is seen as being 'wrong'
- A tradition in the family of symptoms being used at times of crisis to keep the family together

Aldridge & Dallos conclude that suicidal behaviour might be seen as a strategic move to keep the family together in the face of developmental change, which offers a perspective on how some families might negotiate change in some circumstances. I have encountered what appears to be this type of presentation in the Emergency Department of a District General Hospital, whereby I observed in the context of disrupted interpersonal relationships and psychosocial stress how communication might be expressed through self-harm. Sometimes these behaviours were accompanied by symptoms of severe mental illness, sometimes not.

These theories resonate with research into social networks and how they impact on health, shown by Berkman et al (2000) who considered how social cohesion and integration influenced mortality, then offered a way of viewing the possible understanding of how individual pathology might be seen as a function of social dynamics. Berkman et al. suggested Durkheim's work on suicide:

"challenges us to consider how patterning of one of the most physiological and intimate and, on the surface, individual acts rest not only upon the psychological foundations but upon 'patterning' of social facts which, Durkheim argued, in suicide explains changing patterns of aggregate tendency towards suicide" (Berkman et al, 2000 p. 844)

This theory developed from observing countries and other geographic and social groups with stable rates of suicide year after year (Durkheim, 1997), suggesting that suicide relates to an individual's social integration within a group. Berkman et al. linked this with the work of John Bowlby (1980). Bowlby researched early attachments as well as the role of the environment, and suggested the attachment figure must create a secure base to enable the infant to explore and venture forth into the world. He believed that separation of infants from their primary attachment figure was unhealthy, resulting in difficulties processing loss and separation. Whilst these important bonds developed in childhood were felt to provide a secure base for solid attachments,

his theory extended beyond childhood into adulthood, and considered the maintenance of affectional bonds and security in larger systems. Bowlby viewed the attachment of marriage in adulthood as an equivalent. If the relationship and attachment is secure, this provides similar security for the individual. Returning to Berkman et al. (2000) this links with theories about the relevance of social networks, kinship, class, marital roles, culture and context (Burnham et al., 2008; Burnham, 2012) which opens up possibilities for viewing suicide differently.

Whilst this thesis is not primarily concerned with answering the question,

Why do people end their lives through suicide?

Many people including those working in and outside mental health services in the NHS feel the need to know why. Research exists which explores this question. Apart from early seminal work by Durkheim (1997) which debated the contribution and the role of society alongside the potential influences of relationships/attachments in early life, a significant body of research highlights the correlation between mental illness and suicide, which is summarised in the next section.

2.12.1 Introduction to the traditional approach to research into suicide

The majority of research into completed suicide has historically taken the approach of 'psychological autopsy' (Shneidman, 1971). In the late 1950s Edwin Shneidman linked this term with the coroner's original aim of assisting in determining the cause of death, whether it was natural, accidental, suicide or homicide. An essential component of the psychological autopsy was the clinical interviewing of those closest to the deceased, usually the bereaved family, thereby compiling a retrospective assessment of the behaviour and mental state of the person in the period leading up to their death.

Within medicine, the research potential of the psychological autopsy was quickly recognised and became the dominant methodology. While robust critique of the approach has revealed substantial flaws it is important to acknowledge that it has contributed to the field. Using this method enquiry is made into the aetiology, or cause, of the condition or disease and this becomes the subject of investigation, in other words: 'why did it happen?' The detailed study of individual cases took place in order to shed light on the reasons for suicide (Hawton et al, 1998).

As far back as the 1970s Barraclough et al. (1973) found:

*“Virtually all the suicides studied were mentally ill ...
Mental illness is an essential component of suicide; our findings ...
suggest that in Western society suicide in the healthy person is a rare event.”*

Kapur (2009) and again more recently Goldney (2013) assert that approximately 90% of those who die by suicide were suffering from a mental illness. However in an attempt to discern possible benefits and drawbacks of the psychological autopsy approach Henry & Greenfield (2009) observed the impact of the psychological autopsy on 35 interviews from the families of the deceased between six and eighteen months after the death. Results found that the psychological autopsy was helpful to those who participated by allowing them to find meaning in the suicide and reduce feelings of guilt, to find purpose through their altruistic gesture to participate in research and obtain psychological support, to experience connectedness with others, to accept the loss as real and gain insight into their understanding. The negative effects of participation related to concerns about the possibility of the researchers finding cause for law-suits. Three participants expressed concern that the process appeared to focus on the negative attributes of the deceased. Feelings of sadness, guilt and anger were common. The authors concluded that preparatory training for interviewers, as well as ongoing supervision, would assure a reflective and professional stance when undertaking such work.

2.12.2 Alternative approaches to research into suicide

The findings derived from the psychological autopsy approach suggest that the primary reason people end their lives is because of mental illness. But this is perhaps a narrow perspective on a complex and multifaceted process. The theories and perspectives summarised by Berkman et al. (2000) and presented by Marsh (2010) open up this debate. For example it is suggested that the bio-medical model renders academics virtually blind to the most substantial and important issues faced by the suicidal person (Marsh 2010). A one dimensional explanation of suicide does not sit well with the philosophy of systemic psychotherapy that prefers multidimensional perspectives and demonstrates a willingness to tolerate uncertainty and curiosity. I have not included the many psychological autopsy studies within this review as I feel this would only serve to draw more attention, and by association, support to the methodology used. However examples of research using the combination of the psychological

autopsy approach together with attention being paid to psychosocial influences are coming more to the fore and are summarised later.

2.12.3 Argument to abandon the psychological autopsy approach to suicide

Hjelmeland et al. (2014) debates the challenges that mental disorders play a significant role in at least 90% of cases which invites assumptions about a causal, and possibly linear relationship. The evidence base for this appears doubtful as it is derived from interviews with the bereaved family or relative, and is based on a diagnostic questionnaire, as in traditional psychological autopsy studies, so there is a strong possibility of ending up with a diagnosis for the person who has ended their life through suicide.

To support this perspective, Hjelmeland et al. (2014) go on to cite the review undertaken by Cavanagh et al. (2003) which shows diagnoses in psychological autopsy studies based on subjective perceptions, emotions and experiences of the bereaved, or on speculations about questions which, in many cases, cannot possibly be answered with any certainty. Furthermore it might appear that the strong association between mental illness and suicide has acquired the status of reified fact (Berger & Luckman 1966) because of a large number of studies applying this same methodology. Marsh (2010) urges,

“By interrogating the well-guarded certainties of suicide, it may be possible to approach the subject in such a way that the cultural and historical forces that act to ‘form’ suicide and suicide subjectivities are not concealed by references to universal truths but are instead open to scrutiny” (p. 7)

Marsh critiques the fact that suicide has come to be seen as largely a matter of medical and psychiatric concern. Through exploring the construction of suicide over time Marsh strives to shift away from the perception that there is a singular act, indeed that suicide has a singular meaning. It is possible to draw parallels between what Marsh proposes and systemic approaches. As Marsh asserts, there is a need for new freedom of thought to replace those that have come to be constraining. Importantly Marsh is advocating the creation of a space where there is a wider understanding and response to the reality and possibility of such acts. Marsh describes suicide thus;

“Suicide as a discursively constituted phenomena, will always resist complete description, if for no other reason than as a cultural product it lacks any

unchanging essence that could act as a stabilising centre by which to anchor such a description” (Marsh, 2010, p. 9).

What Marsh asserts are the “truth effects of problematising” which are incumbent in contemporary constructions of suicide, whereby society has come to think about suicide in terms of individual mental illness and risk. As a consequence:

“an individualised, internalised, pathologised, depoliticised and ultimately tragic form of suicide has come to be produced, with alternate interpretations of acts of self-accomplished death marginalised or foreclosed” (Marsh, 2010, p. 219)

Indeed in defining and describing death by suicide, it may be said that such deaths have come to be understood as individual events disconnected from issues of social justice, practices of exclusion and oppression, politics, stigma and power relations. To further support this argument, Webb, (2010 p. 40) states:

“As a person who has recovered from persistent suicidal feelings when looking at the academic discipline of suicidology, it feels like the ‘experts’ are looking through the wrong end of their telescope with their remote, long distance, objective empirical view [which] transforms the subjective reality and meaning of the suicidal crisis of the self, that is the actual suicidal person, into almost invisible pinpricks in the far distance”

Clearly, whether or not a person who ends their life has a mental disorder remains a topic of much debate. Indeed Boyle & Johnstone (2014) offer alternatives to the paradigm of psychiatric diagnoses. They suggest a biological approach to research is flawed and has comprehensively failed to provide meaningful insights and urge:

“Letting go of the illusionary safe certainty of psychiatric diagnosis”

then being more willing to face the reality of human suffering and the issues this raises. There are many complicated issues to attend to when considering this subject, particularly as:

“Suicide is found to occur in families that are psychosocially burdened with a higher prevalence of psychiatric disorder with possible inter-generational effects” (Goldney, 2013, p. 75).

Working with families and carers is one thing, how to influence systems within and outside the spectrum of care is another, which I will discuss later.

2.13 Research into suicide applying qualitative approaches

Having considered reductionist scientific approaches to researching suicide I will now consider the alternatives. The results may be entirely different when the bereaved are invited to speak freely about the issues they think were central to the suicide. Owens et al. (2003) asked diagnostic questions of the bereaved and reported that 68% suggested the person who committed suicide qualified for a psychiatric diagnosis. However when the interviews were analysed qualitatively, very few made reference to psychiatric disorders. In addition, almost a third of cases (32%) did not report a mental disorder. This group was distinguished by a lower rate of mental illness than previously recorded by other studies. These findings highlighted the difficulty of identifying individuals outside specialist mental health care at risk of suicide and consequently support the continued development of broad population-based measures rather than the targeting of high-risk groups. Owens et al. (2012) explored the role of social networks in suicide prevention with the intention of discovering what the suicidal process looks like by listening to views of the relatives of the deceased about what they saw and heard, how they interpreted this and what difficulties they encountered prior to the suicide.

2.13.1 Research into male suicide

The Samaritans have investigated 'Men, suicide and society' (Scowcroft, 2012) and posed the question:

'Why are men in mid-life from disadvantaged backgrounds more at risk of suicide?'

Their findings assert that social issues influence men felt to be at increased risk who ultimately end their life, because men compare themselves against a 'gold standard' which prizes power, control and invincibility. Furthermore, men in mid-life now form part of what is referred to as the "buffer" generation which implies a sense of uncertainty about whether to behave like the older and traditionally strong silent style of their fathers or more like their younger more progressive individualistic sons. Scowcroft suggests that men in midlife remain overwhelmingly dependent on a female partner for emotional support. In addition, a number of significant findings were found:

- Personality traits which may interact with other factors like deprivation, unemployment, social disconnection and events that act as a trigger, like job or relationship loss

- More men tend to respond to stress by taking risks, misusing alcohol/drugs
- Challenges in mid-life through experiencing more mental health problems compared to younger and older people
- Emotional illiteracy – with men are much less likely to have a positive view of counselling/therapy

Therefore men living in these circumstances are up to 10 times more at risk of suicide than those living in the most advantaged conditions. The Samaritans made recommendations for policy makers and practitioners including:

- Tackling gender and socioeconomic inequalities
- Implementation of suicide prevention policy and practice must take account of the views of men and what it is to be a 'man'
- Recognise that for men in midlife, loneliness is a significant risk
- Make links between alcohol reduction and suicide prevention strategies
- Support GPs to recognise signs of distress

This research has become even more relevant and underscores the recent rise in suicides of men in this age group (NCISH, 2015). SANE conducted research in 2013 taking an alternative approach to suicide prevention (Gibson et al., 2013). Researchers talked to people who had lost a close friend or relative through suicide in the last five years, and also people who had attempted suicide, together with close friends and relatives referred to as 'significant others'. The study consisted of 25 people bereaved by the suicide of 8 women and 13 men aged between 21 and 63 years, only one in four of which had been in contact with mental health services. Using grounded theory, a methodology originally developed by Glaser and Strauss (1967) which asserts that human behaviour develops through interaction with others and people are active participants in creating meaning, three main themes were felt to be contributory factors to the process of suicide. Lack of 'contingent' worth, based on the approval of others and 'non-contingent' worth, were explored, which highlighted the importance and value of a person maintaining a sense of worth, the absence or diminution of which may have heralded increased vulnerability. Lack of trust was felt to be significant. The authors found that these issues, which led to difficult thoughts and feelings being hidden, and an inclination to self-reliance in a person, were common. Also they made reference to a third factor; 'suicide

exhaustion', which included anxiety and sleep disturbance, and appeared to have become superimposed upon the person already struggling.

This research offers new insights into processes and events leading up to a person ending their life and begins to address the question of why in a different way. Indeed the authors considered the commonalities in participants' stories as being a limitation of the study, and thought there were probably other experiences yet to be uncovered. This strengthens the argument for further research on background and risk factors, which may pose questions about the roles of men and women in society today, which I will discuss next.

2.13.2 Young men and suicide

In their study of suicide in young men aged between 18-39, Rasmussen et al. (2014) interviewed mothers, fathers, siblings, girlfriends and friends, as well as examined the suicide notes left by the deceased, which made it possible to analyse data from both a developmental and relational perspective. This connected with findings in Kjørseth's et al., study (2010) where analysis showed that early in life men had developed a fragile, performance-based self-esteem which led them to being vulnerable even when they encountered small setbacks. These studies indicate a particular susceptibility and vulnerability in men through experiencing themselves as unsuccessful and rejected when they felt they had failed to live up to their ideal of who they should be. Instead of lowering performance expectations, there appeared to a tendency to become overwhelmed by strong emotions, particularly shame and anger. For them it seemed suicide became the way out of a state of intolerable mental pain (Rasmussen et al., 2014).

2.13.3 Research into suicide taking a gender and cultural perspective

Owens & Lambert (2012) consider gender, identity and accountability in their publication 'Lay portrayals of suicide in late twentieth-century England' and concluded that in the pursuit of 'medicalisation' of female and male distress, the preoccupation with mental illness may have resulted in cultural and contextual understandings of suicide being obscured. Kizza et al. (2012, a.) highlighted contributory influences including culture in their research into suicide in Northern Uganda. They investigated psychosocial circumstances and revealed that perceived loss of dignity and social values were central. Lack of hope for the family's future, with a sense of overwhelming responsibility and mental

illness were circumstances found to precede suicides. This meant that the men in rural communities felt disenfranchised and disempowered after the protracted war in Northern Uganda which may have contributed to suicidal behaviour. Multidisciplinary suicide prevention with an emphasis on helping both men and women understand and deal with the many social changes was therefore recommended. Kizza et al. (2012, b.) also explored why women in Northern Uganda killed themselves. Women were found to have been through traumatic experiences during the war and the decision to take their own lives seemed due to a combination of unpleasant events and experiences occurring within the last three months prior to the suicide. These experiences were captured in two main themes: having no control over their lives and receiving no care. In addition, changes in the traditional gender roles, for example: 'men's quest for their lost masculinity, and women's attempts to fight for their rights, perceived as a cultural transgression' were also felt by the authors to have contributed.

These studies offer insights into developing an understanding of the influences of culture and social context on the rates of suicide. Again it is evident that psychosocial, cultural and other factors apart from mental illness featured in these suicides. This led me to wonder about gender roles and experiences in social contexts. What is happening to men and women in society? Where is the sense of purpose, belonging and the influences of family /social networks, in particular when times are hard? This will be revisited later.

2.13.4 Literature into the impact of suicide upon families and carers

The death of a close family member is one of life's greatest stresses (Holmes & Rahe, 1967). Grief following suicide may entail particular difficulties (McIntosh, 1987). Therefore considering the experience of bereavement after a suicide is important, not only because of our humanitarian responsibility toward alleviating collective distress, but also to prevent complications arising from the aftermath of completed suicide, one of which can be further suicide.

According to Clark (2001) suicide may throw a whole community into confusion. Bereaved families face particular dilemmas, such as what to tell others, whether to hold a public funeral, intrusion by the police and legal processes. The bereaved may also harbour intense feelings of guilt, rejection and shame and

feel like they have to question their value system. Children and young people may develop feelings of insecurity and responsibility. They may have difficulty disengaging from roles modelled by an older and respected person. To add to this, friends and neighbours may feel out of their depth and fail to support the bereaved family. Sometimes inappropriate reaction from the media may cause further distress. Furthermore language such as “commit” suicide, and metaphors relating to methods of suicide may cause distress because of judicial connotations and unpleasant mental images (Martin et al., 1993). Clark called for suicide ‘postvention’, a term first used by Schneidman (1968) when referring to the:

“Helpful activities which occur after a stressful or dangerous situation” (p.19).

Postvention refers to those activities developed by and with suicide survivors in order to facilitate recovery to prevent adverse outcomes including suicidal behaviour (Andriessen, 2009). The concept invites the question:

Can postvention be prevention?

As mentioned earlier, a systematic review (McDaid et al., 2008) of the gap in providing help and support to the bereaved began to be addressed when Hawton and researchers developed resources to help those bereaved by suicide (Hawton et al., 2008). This culminated in ‘Help is at hand for people bereaved by suicide and other traumatic death’ which has become widely available and very well received by families and staff alike. However, Baume (1988) and Cerel et al. (2008) have highlighted that little research exists which examines the consequences of suicide on social and family networks. Cerel et al. explored family changes following suicide, the impact upon individual members of the family and the family as a whole. They attempted to determine what is helpful to families in the aftermath of suicide. The study considered the impact of losing a child and also an older adult, thereby aiming to identify issues that need to be explored and resolved in survivors. This provided some possible questions for each group and the study made recommendations about future research.

Lindemann & Greer (1953) suggested that the survivors of suicide may often be viewed more negatively than other types of survivors, resulting in disconnected communication, social isolation, blame, projection of guilt and scapegoating. This remains the case according to Sudak et al. (2008). Traditionally suicide and suicide bereavement is felt to be associated with complicated grief, with

early studies describing the presence of major psychopathology amongst families, friends and relatives. This introduces possible concerns for the risk of the survivor regarding attempting or completing suicide themselves (Worden, 1982).

This is particularly relevant to the research of suicide aftermath in rural communities. Zhang et al. (2004) found a strong correlation between family members of the person who died, rural residents and those who had lived with the person, and major depression and suicidal behaviours. Hypotheses were drawn that survivors living in rural settings appeared more significantly affected. The psychological impact of suicide bereavement was found to include feelings of personal diminishment, lowered self-esteem, feelings of inadequacy, deficiency, failure, guilt, rejection and abandonment, in addition to anger.

Begley & Quayle (2007) have studied whether grief experiences associated with suicide are similar or different to other losses, by interviewing eight adults bereaved by suicide. Four main themes emerged from the analysis, as follows:

- *'Attempts to control the impact of the death'*

with an overwhelming need to

- *'Make sense of the death'*

coupled with the third theme of

- *'Social uneasiness'*

and finally a sense of

- *'Purposefulness'*

to their lives following their relative's suicide.

The conclusions drawn from this study suggest that suicide bereavement is shaped by the bereaved family member's life experiences, relationship with their deceased relative and their perception of social interactions after the event. 'Meaning making' appeared to be particularly important for the suicide survivor. According to Maple et al. (2010) in their qualitative research project of 22 bereaved parents who had experienced the suicide of a young person in the family, commonly they felt unable to talk about their child's life, death and their

resulting grief. These parents experienced feeling 'silenced' by others as well as silencing themselves.

Dyregrov (2011) proposes that suicide postvention be given a more prominent position and quotes Shneidman (1973):

"A person's death is not only an ending; it is also a beginning – for the survivors. Indeed, in the case of suicide the largest public health problem is neither the prevention of suicide ... nor the management of attempts ... but the alleviation of the effects of stress in the survivor victims of suicide deaths whose lives are forever changed and who, over a period of years, numbers in millions."

Dyregrov (2011) explored what is known about the perceived needs of suicide survivors in different parts of the world, of which there are few. The studies that were found originated in the Western hemisphere and suggested a common need for peer and social support as well as professional help which respected individual needs and preferences. It seemed that even in societies where the stigma about suicide may have receded some communities still found it difficult to talk about their needs. Dyregrov therefore identified the need for more culturally sensitive research.

2.13.5 Research into interventions for survivors and families after suicide

Jordan & McNenamy (2004) asserted that mourning after suicide was frequently a difficult experience and called for more research into support for survivors. Similarly Cerel et al. (2008) urged research to attempt to understand the impact of suicide upon the family, in order to determine how best to help survivors. In a systematic review of the effects of interventions for people bereaved by suicide McDaid et al. (2008) found a single study of cognitive behavioural family interventions of four sessions with a psychiatric nurse, a 10 week bereavement group for children and an 8 week therapy group for adults. These interventions appeared to provide some benefit, although the study was not felt to be robust enough to make definite recommendations for practice.

Flexhaug & Yazganoglu (2008) recommended presenting best and promising practices in suicide bereavement support services in Alberta, Canada after reviewing the literature evaluating bereavement groups facilitated by a survivor and a professional with experience of counselling survivors of suicide. Results reported that this was well received alongside individual support.

Notwithstanding and regardless of what intervention was provided, it felt

prudent to design links between suicide bereavement services and a mental health provider, at a minimum, for support, advice and onward referral, with evaluation and further research to follow. Limitations reportedly included the absence of a standard service delivery model combined with the acknowledgement of a lack of reliable and valid evaluation tools. In addition, there was no exploration of research into suicide 'contagion' and it remained unclear as to how much time would pass before support services impacted the lives of survivors.

McNenamy et al. (2008) presented the results of a pilot study into 'What do Suicide Survivors Tell Us They Need?' They asserted that few studies have examined the natural coping efforts of survivors themselves, nor are their specific problems identified. They used a newly developed needs assessment survey with sixty three adult survivors to examine four types of natural coping: practical, psychological and social difficulties; formal and informal sources of support; resources utilised in healing; and barriers to finding support since. Results indicated that participants reported experiencing high levels of psychological distress since the suicide, including elevated symptoms of depression, guilt, anxiety and trauma. Participants also experienced substantial difficulties in social contexts, for example, in talking with others about the suicide. The majority of the sample viewed professional help as beneficial although many informal sources of support were also valued, including one-to-one contact with other survivors.

An Australian study examined post suicide outcomes for those closest to the deceased, particularly family and friends (Flynn & Robinson, 2008). The provision of information, resourcing and education was found to be of importance to bereaved families, as was working with the family to help facilitate the grieving process by renegotiating roles and expectations. Natural postvention initiatives to ensure consistent approaches and good practice were felt to be important, as was further qualitative research into the responses of children and culturally diverse groups. Depression and a lack of information served as barriers to seeking help. Those who reported higher levels of functional impairment reported psychological distress and social isolation as obstacles to help. This was echoed by Jordan et al. (2011) who also recommend research with a longitudinal and more inclusive sample to build on preliminary findings and provide a solid foundation for evidenced-based interventions.

A systematic review of 49 post-suicide intervention programs was presented by Szumilas & Kutcher (2011). Results showed few positive benefits from school-based postvention programs and one study reported the negative effects of suicide postvention. However gatekeeping training for proactive postvention was reported to be effective in increasing knowledge of possible interventions. Use of 'Outreach' intervention at the scene of suicide was found to be helpful through enabling those effected to attend a support group and access help in adapting to their loss. Additionally it was found that family survivors who had contact with counselling postvention reported reduced levels of psychological distress.

Omerov et al. (2013) developed a questionnaire from a controlled study of 666 parents in Sweden bereaved by suicide and 377 non-bereaved, which considered the participants' perception of involvement in the research, their daily living, psychological morbidity, professional actions and other experiences. Omerov found that by involving parents early in the research process researchers were able to create a questionnaire that generated a high participation rate. Indeed when Visser et al. (2013) evaluated the effectiveness of a community-based crisis intervention programme for people, referred to as 'StandBy', they found reduced adverse health and social outcomes. This reinforced results from previous studies suggesting postvention can be effective in the reduction of suicidality in survivors of suicide.

Research into suicide and trauma are often linked. As referred to earlier, NICE (2005) recommends 'watchful waiting' for those exposed to trauma, although grief is of course a natural process. A wide variety of language is used to describe the process of grief: grief can be 'worked through' and 'resolved', people are guided to 'move on', find 'closure', 'come to terms with' what has happened, be 'reconciled' and so on. As a systemic practitioner I feel it is important to pause for a moment and, as McGoldrick et al. (1992) urge, adopt a culturally sensitive approach that resists and challenges widespread assumptions about mourning, such as the need to 'get it out', 'get over it' and 'move on'. Wheeler (2009) suggested a solution-focused stance when working with the bereaved, as without giving people the opportunity to name the outcome, there may be a danger of influencing the conversation with one's own views. For example, ideas about whether there is an afterlife, whether or not it is possible to sustain a relationship with someone after they have died and how one should carry on living. These questions are discussed later; however

Colmer & Suresh (2009) suggested creating a climate that fostered empathy and tolerance of different reactions in a family bereaved by suicide.

When suicide occurs during an episode of hospital or community care there are profound ethical, legal and spiritual challenges.

“There are perhaps unanswerable questions that need to be brought into discussion, about ‘why’ and ‘what if’” (Rycroft, 2004, p. 253)

Some tragedies and human suffering cannot be ‘therapised away’ (Hoffman 1992) and whilst it is important to promote what can be done in people’s lives to help make a difference, it is also important to recognise and share our limitations.

Hoffman (1992) suggests that overwhelming grief after the death of a loved one is a natural human process that does not necessarily need therapy or expert input which might ‘professionalise’, indeed even ‘pathologise’, normal grief reactions. Caution is therefore advised, with the need to be aware of the pull to “rescue”, combined with careful thought to the best timing for professional involvement. It is of course important always to maintain curiosity and keep an open mind in the context of bereavement after suicide (Shachar, 2010).

Indeed seeing and understanding suicide in contexts other than mental illness is highlighted in the second report of the Suicide Support and information System (SSIS) Arensman et al. (2013) which includes recommendations from a systematic approach undertaken in Ireland advocating the proactive facilitation of support for families bereaved by suicide. The association between the impact of the recession, including unemployment, financial problems, loss of possessions and suicide as identified by the SSIS, underlined the prioritisation of suicide prevention during times of economic recession. This supports the view that social and contextual circumstances play a part in the very complex process of suicide.

2.13.6 Is the experience of death by any cause the same as suicide?

In Watford’s study (2008), ‘a reflective exploration’ of her experience as a survivor of spousal suicide, the rationale for concentrating on the differences and/or similarities between people bereaved by suicide and people bereaved by other kinds of death is questioned. She inquires whether it might be more helpful to compare suicide survivors to each other. In a literature review Botha et al. (2009) found that bereavement after suicide as opposed to other modes of

death rendered individuals more susceptible to enduring and complicated grief reactions. Factors found to indicate that suicide bereavement is distinct, include survivors more often experiencing feelings of rejection, responsibility, guilt and blame, with feelings of shame and embarrassment interacting with a sense of stigmatisation. In addition, reports indicated ambivalent, challenging and negative relationships with service providers after suicide. Bolton et al. (2013) stated that suicide bereavement remains understudied and poorly understood. When examining outcomes of parents bereaved by the suicide of their offspring in comparison to non-bereaved parent controls and parents who had offspring die in a motor vehicle crash (MVC), findings concluded that suicide bereavement was associated with an increased rate of depression, anxiety disorders and marital breakdown. However, parents who lost offspring to suicide also appeared to be a vulnerable group even prior to their offspring's death.

The importance of suicide bereavement has been emphasised by the International Association for Suicide Prevention (IASP), which has established a task force on suicide bereavement. Together with the World Health Organisation, IASP has published guidelines for establishing suicide survivor support groups (WHO, 2008). Considering there are almost 1 million suicides annually worldwide, this presents a considerable population of the bereaved. It seems clear therefore that bereavement through suicide is indeed distinct from bereavement from other death and links with NICE (2005) recommendations following the experience of trauma. Whilst this research was not designed to directly address such issues, it is important to consider and reflect upon anything that might prove useful to those affected in terms of adding to the 'sense making of suicide'.

2.13.7 Effects of suicide upon siblings

The literature about the loss of a sibling through suicide suggests that they may become forgotten mourners and expected to be strong for others. In a qualitative study of 45 sibling survivors Powell & Matthys, (2014) found that the uncertainty and loss siblings experience is not well recognised. They proposed some management responses that may be helpful.

2.13.8 Research into suicide by people in the older age group

Kjølseth (2010) found that suicide among the elderly (between 65–90 years of age) seemed linked to perceptions of how they had lived their lives and what their experiences meant when confronted with old age. Many had lived in difficult circumstances, both when growing up, including the loss of important carers, onset of illness and poverty, then serious losses and challenges later in life combined with a unwillingness to accept help. Age-related reduction of functioning resulted in feeling a loss of identity and that life was a burden. Suicide seemed to offer a feeling of regaining control. These findings were reflected by Bazalgette et al. (2011) who also highlighted the relationship between physical, chronic and terminal illness.

2.14 Research into the impact of suicide upon healthcare staff

Patient or client suicide can affect clinicians professionally and personally. There are a variety of reports claiming psychological and behavioural changes occur in response to suicide, with some research setting out guidance for supporting staff after a suicide (Bird, 2009). Some of the feelings experienced after such an event include shock, loss, anger, failure and denial, although experiences are unique to each individual. Joyce & Wallbridge, (2003) found professionals who discovered the deceased, and had physical contact by attempting resuscitation, were sometimes left with longstanding sensory images. Hendin et al. (2000; 2004) found that one third of professionals experienced severe distress when a patient ended their life through suicide which, in some instances, continued for one or two years after. Little (1992) argued there are three overlapping phases professionals may experience after the suicide of a patient: initial shock and loss of control followed by stunned disbelief, distractibility, disorientation and bewilderment which lasts several days. This can be followed by feelings of guilt, depression and anger lasting up to two months. As the emotional intensity lessens, opportunity for personal and professional growth or prolonged disability arises. Individuals may withdraw from working either physically or psychologically which might result through increased sickness, absenteeism (Feldman, 1987) or taking another job (Cotton et al., 1983). Self-confidence and self-esteem may be diminished and this may impact on other areas of life including family relationships. Social isolation may occur (Alexander et al., 2000). Factors that may impact upon the professional include whether the individual feels responsible for the death, concerns for the

bereaved family and having a close therapeutic working relationship with the deceased (Gaffney et al., 2009). In addition, feeling blamed by the family, colleagues or the organisation and the potential threat of a lawsuit (Hendin et al., 2004; Marsh, 2010), as well as individual characteristics including gender, age and level of professional and life experience (Grad et al., 1997, Kovac & Range, 2000).

Considering the link between physical illness, mental health and suicide; though hospice staff may regularly care for dying patients, the impact of suicide in this group has been understudied. According to Fairman et al., (2014) who examined the effect of suicide in the palliative care setting on 186 hospice staff, self doubt, guilt, changes in clinical practice and professional attitudes were prevalent. Staff described using team based support strategies, debriefing and personal /spiritual practices. Recommendations were made for future support which included facilitated debriefings, individual counselling, spiritual practices, leave of absence, self-care activities and educational interventions. In previous research I have found reactions to be quite variable, for example shock and disbelief for some, dismissal by others (Bird, 2009).

2.14.1 Guidelines to assist clinical staff after the suicide of a patient

Guidelines to assist and support clinical staff after the suicide of a patient are set out comprehensively by Grad (1997; 2011), Grad & Michel (2005), Pallin (2006) and Gaffney et al., (2009). To reduce the impact of a suicide on staff, support in four areas is suggested: administrative, institutional, educational and emotional. These include establishing when to offer help (as soon as possible after the suicide) and when staff are made aware of the event. Grad recommends that all staff who worked with the patient are informed about the suicide, as well as the institution's management, relatives, and other key personnel, for example the patient's general practitioner. Arrangements have to be made so that everyone who wants to attend a meeting can do so, despite their usual working commitments. Suicide affects clinical staff at an emotional and personal level. Speaking from my own experience, support for such an experience is patchy and inconsistently applied. Indeed if provided the quality and usefulness of such interventions should be evaluated. Often while guidelines exist for supporting staff in contact with the patient, no mention is made as to processes for supporting senior staff and managers. Returning to policy guidance, the Cochrane collaboration (Rose et al 2009), conducted a

systematic review of psychological debriefing for preventing post-traumatic stress disorder (PTSD). To address the apparent lack of empirical evidence of efficacy, this was the third review of reviewing 'debriefing' since 1997. Within this review the authors concluded that one session of individual debriefing neither prevented the onset of PTSD or reduce psychological distress, and therefore recommended that:

"Compulsory debriefing should cease" (Rose et al., 2009, p. 2).

This supports more appropriate and proportionate approaches via the 'screen and treat' model (NICE, 2005) which imposes structures resulting in the 'drowning out' of human experience and suffering.

2.15 Research into the experience of the relationship between families/carers and service staff after a suicide

Before bringing this review to a conclusion, it is important to include any study into the experience of the relationship between families and mental health staff after suicide, which proved difficult to locate. One Australian study by Leggatt & Cavill (2010) investigated the experience of 15 family carer participants. The following quote provides a flavour of the findings:

"I had not heard a word from these people, my son is now dead ... absolutely nothing was offered afterwards ... I thought they would call us and just talk to us, but there was nothing ... it would have been helpful to have at least acknowledged that my son had existed" (Leggatt & Cavill, 2010, p. 29).

Unresponsive mental health services were viewed as a major risk factor contributing to the eventual suicide of the loved one. Family carer's reported voicing concerns for their relative's safety, but treatment interventions were felt to be too brief, discharge from services was premature and post-discharge support was not provided. A lack of dignity and respect, information and support was commonly reported. The carer's reported lack of communication between services led to them feeling excluded:

"I was left to cope on my own; to the point I had a nervous breakdown myself" (p.28).

There was felt to be a discontinuity of care, a lack of ongoing risk assessment and poor follow up post-discharge. Family carers found that support and information was sadly lacking, with one family member speaking of his concern that his family's bereavement needs came second to the desire of staff to protect themselves against potential litigation:

“A couple of nurses were terrific but they closed up shop when she died ... a wall of silence” (p.28)

Leggatt & Cavill made recommendations on behalf of the family carers including highlighting that family carers must be treated with respect and not ignored, blamed or isolated in their grief. In addition it was strongly advocated that training must be improved for medical staff in Emergency Departments and risk assessments improved in mental health services. However their findings were unsettling to say the least.

2.15.1 Summary of the literature and background context

The research and background information summarised above provides wide-ranging views and useful ideas on the subject of suicide. The original psychological autopsy methodology has been significant in a variety of areas; however there is a strong argument for change heralded by the advent of alternative qualitative approaches. Linking concepts from systemic and family therapy, particularly in the context of the NHS, opens up thought and debate on this subject, which is crucial to developing useful theory and knowledge that furthers understanding, particularly in relation to diversity and discrimination, issues of poverty, prejudice and illness, as well as other factors that affect a person's sense of identity.

National statistics suggest the suicide rate in mental health hospitals is reducing, however it is on the increase in Home Treatment/Crisis Resolution teams in the community and staff report that closer working with the patient's family would have reduced suicide risk by more than 10% (NCISH, 2015). The risk and potential for suicide remains high on the agenda in the NHS, particularly but not exclusively in mental health services. NHS England aspires to a rate of zero suicides and the review by the CQC (2015) recommends that local care concordat (DoH, 2014) groups ensure crisis care is focused on providing accessible, available help and support for all those who require it. However reports in 2013 by Francis, Keough and Berwick, (2013) revealed some appalling examples of poor standards of care within an NHS where budgets are shrinking and there remains a disparity between physical and mental health care funding.

Reports into the effectiveness of risk assessments and implementation of recommendations show improvement is required. This has wide ranging implications for staff and organisations, including the need for openness and

honesty alongside the potential for compensation claims if NHS Trusts are found to fail in their responsibilities. More research into interventions provided for families, carers and staff after suicide, including postvention, is recommended by a number of bodies, with caution urged against routine 'debriefing' (NICE, 2005). As Rycroft (2004) has suggested, out of something so tragic there is the potential to learn and grow if provided with support. Consequently there are calls by many including the Strategy for Preventing Suicide in England (DoH 2013) for more research into this area and support for those bereaved by suicide. SANE (Gibson et al. 2013) and the Samaritans (Scowcroft, 2013) have also provided useful insights into this field. There are large amounts of research into the impact of suicide upon families, carers and staff within the NHS, which show that the effects can be life changing and may increase the likelihood of becoming mentally unwell themselves as well as suicidal.

It is important to acknowledge that families and relatives of the deceased will be significantly affected by suicide as well as the staff who delivered care to the person, although the experience of the relationship between families, carers and mental health staff does not appear to have been widely studied apart from by Leggatt & Cavill (2010).

Bringing this literature review chapter together has helped me be clear about what exists already and where there are gaps in the literature. The literature above is but a small part of what exists on the impact of suicide on various different groups of people, including families, carers and staff. Having occupied multiple positions in relation to suicide myself, I can only wonder at why those affected do not seem to have their emotional and psychological needs met. The balance between legislation, policy and human suffering appears to be out of kilter. However, this has added fuel to my desire to research this subject in order to discover interventions and strategies for support that could make a difference.

3. Methodology

3.1 Introduction

I will discuss the methodology of this study in the following chapter including:

- The epistemology
- Qualitative research and Grounded Theory
- The interplay between theory, participants and the research
- Systemic, Family Therapy and relational dimensions that influenced the study
- Evolution of the study design

3.2 Epistemology

The effects of patient suicide on staff has been a constant theme throughout my career in the NHS; however I do not recall receiving any training to assist me in this. I remember vividly my first experience of patient suicide. In the support offered and processes in place there was a sense they were “fumbling through”. I have conducted many serious unexpected event reviews into incidents, including patient suicide. In addition I have convened post-incident staff support meetings following the death of a patient, which included group and individual clinical supervision. This work is challenging, as taking account of and acknowledging people’s emotions and responses in highly stressful situations is a complex undertaking. Nonetheless, I have learned a lot from these experiences, which have been similar to the therapeutic work of systemic family therapists. However, having a theory base does not mean I necessarily have answers, more that I am interested in listening and discovering with people what it is like to go through the experience first-hand. For example, I am interested in the emotions experienced after suicide by the bereaved family, the way they feel they were treated by the service and what it was like for staff to deliver ‘bad news’. In addition to the professional positions I occupied as a nurse and family therapist, following a complaint to the Trust by a bereaved family about the way they were informed of their relative’s suicide, I developed with the Trust training department a training package for ‘Breaking Bad News’, adapted from Hart (2009).

As Finlay (2002) urges, it is imperative to examine one's own motivations as a way of understanding others and, as such, the kind of knowledge the researcher might be laying claim to (Charmaz, 2006); therefore as preparation for this work I carefully considered my position on suicide. My position on suicide incorporates thinking on suicide from a range of disciplines, including systemic psychotherapy, nursing, medical, etc. and I came to realise that there was no 'correct' position, therefore my broad range of experience and knowledge in the area of suicide meant that my research ought to be well-anchored. It seems important to make mention at this juncture of what is referred to as:

"Claims of knowledge about subject of study, guiding interests, sensitising concepts ... provide a place to start, not to end! ...All provide vantage points that can intensify looking at certain aspects of the empirical world but they may ignore others. Hence we may begin our studies from these vantage points but need to remain as open as possible to whatever we see and sense in the early stages of the research." (Charmaz, 2006, p. 17)

With this in mind, the epistemology guiding this research has been concerned with meaning-making to develop knowledge that assists in the understanding of the subject matter. A constructivist epistemology asserts that through various constructions, which might include the use of language or discourse, we individually construct our knowledge. Whilst this is important, I feel that social constructions of meaning, specifically the way knowledge is created by and between persons, is extremely relevant. My professional practice in everyday life seems to match a social constructionist approach. Without doubt it is difficult to be completely objective; however in my opinion, choosing or perhaps realising this epistemological position, can help to explicate views and opinions on things like concepts of truth, knowledge and reality whilst taking into account the larger social context.

Qualitative research recognises the importance of values, context, setting and the frames of reference of the participants. Furthermore, qualitative research exemplifies the way in which the researcher and participant enter and communicate, which is a vital and influential element of the research process. Indeed, research that is conducted using qualitative methods acknowledges the existence and study of the interplay of multiple views and voices. It also allows for the construction of reality and knowledge to be mapped out. Taking into account that much research into suicide has been undertaken from a quantitative standpoint, I felt that a qualitative approach would offer fresh

perspectives. I wanted to provide an opportunity for the people involved to talk and be listened to, namely the families who had lost a family member through suicide and the staff who were involved. As Charmaz (2006, p. 14) points out:

“Methods extend and magnify our view of studied life and, thus, broaden and deepen what we learn of it and know about it.”

As I have been concerned with studying social processes “from the bottom up”, the discussion and reflections about how to go about it seemed to direct me towards a qualitative naturalistic design. I was curious to trace patterns of social interaction that give rise to particular identifiable social process (Willig, 2008). Furthermore I wanted to be able to hear first-hand from those most affected and explore the meaning that people attach to their social world (Charmaz, 2006). As Burr (1995, p. 126) tells us:

“Our understanding and experience of ourselves is laid down by beliefs about being a person that are implicit in our language. The structure of the language we are born into determines the kinds of beliefs and fundamental assumptions we adopt about the human race, nature and live them out in everyday interactions with each other”.

Furthermore the philosophy of phenomenology, when applied to social science, emphasises that:

“social ‘facts’ are characterised and recognised by their ‘meaningfulness’ to members of the social world and social scientists that follow this tradition assert that the investigator must aim to discover these social meanings” (Bowling, 1997, p. 112).

The effect upon families and staff members of suicide would, I felt, undeniably influence the beliefs people involved held about themselves and the deceased, and the meanings attributed to those beliefs. Therefore it was imperative within this study to use a design which allowed their voices to come through. I wondered how families explained and make sense of suicide, then incorporated the event into their family history, how the experience found a place in their relationships, and how they viewed the organisations that might continue to treat them in future. Similarly I wondered how professionals integrated such an experience into their everyday lives. The design also needed to incorporate and acknowledge the role of the research investigator. As mentioned earlier, working in the field of mental health with people who are suicidal is familiar to me therefore what I as an individual brought consciously or otherwise to the process will have, to some degree, been biased by my pre-existing beliefs and assumptions, which in turn have been influenced by my own personal and

clinical experiences. Therefore I attempted to build into the method and design my reflections and some consideration of how my bias affected the data.

3.3 A qualitative research study interested in meaning

Qualitative research typically is interested in how people make sense of the world, how they experience events and create meaning. Therefore qualitative researchers:

“Tend to be concerned with the quality and texture of experience rather than the identification of cause and effect relationships” (Willig, 2008, p. 8)

This resonated with my individual style and practice of family therapy/systemic psychotherapy within the clinical setting and presented itself as the closest fit to what the study was all about.

“Social constructionism urges us to be ever cautious and suspicious about our assumptions that the nature of the world can be revealed by observation and that what exists is what we perceive to exist” (Burr, 1995, p. 3)

One of the challenges in researching this subject was keeping separate my role as researcher from my role as clinician. Thomas (1993) suggests:

“A researcher must take the familiar, routine and mundane and make it unfamiliar ... gain distance from your preconceptions and participants’ taken for granted assumptions about the research so that you can see it in a new light”.

It seemed reasonable to expect that preconceptions around grief and bereavement, as well as suicide, would be present, at least for the relatives of the deceased. Bereavement theory guided me to be prepared to listen and acknowledge strong feelings such as anger, blame, guilt, regret and disappointment. Therefore acknowledgement of the participants’ voices and views about death formed a fundamental part of the research.

“Acknowledgement is an explicit expression of something already known (by the speaker at least) which is communicated to another person ... it usually occurs as a process of articulation through which some particular knowledge is brought into clear awareness, to stand out in sharp relief, to be attended and responded to” (Tomm & Govier, 2007)

3.4 The interplay between theory, participants and researcher

According to Illingworth (2006) knowledge cannot be understood without appreciating the meaning that individuals attribute to that knowledge, which includes their thoughts, feelings, beliefs and actions. Qualitative research has

certain philosophical underpinnings about the social construction of meaning that I as the researcher hold. Grounded Theory, originally developed by Glaser & Strauss (1967) was selected for data collection and analysis resulting from the study. The theoretical base for Grounded Theory is symbolic interactionism, which stresses that human behaviour is developed through interaction with others, and through a continuous process of negotiation and renegotiation (Morse & Field, 1996). As the theory suggests, people construct their own reality from symbols around them through interaction, rather than by static reaction to symbols.

Therefore individuals are active participants in creating meaning in a situation and the purpose of Grounded Theory is to generate explanatory theory around human behaviour, to allow new theories to emerge from the data through induction, as opposed to other methods of research more concerned with conducting research through observation or interpretation. For example interpretivists argue that it is possible to objectively understand the subjective meaning of an action and interpret this as the original meaning of the action (Schwandt, 2000). Whilst useful this approach does not fit for me as a researcher. The criss-crossing of theory combined with information from participants in the form of data, and my constant presence as a researcher; were the key ingredients of the study. This is what Glaser (2002) referred to when discussing Charmaz and her use of Grounded Theory, whereby she did not only accept data as it was heard, but applied her own meanings and sought mutual interpretation from the participant.

It might be said that advocates for social constructionism and philosophical hermeneutics conclude that individuals are:

'Self-interpreting human beings and that language constitutes this being'
(Schwandt, 2000, p. 198).

However, according to Illingworth (2006) hermeneutics also embraces the potential of conversation and interpretive practice to disclose meaning within a dialogic encounter. This allows for an exploration of meaning. Grounded Theory research methods draw on the interplay between researcher and participants' voices in making sense of a situation. It struck me that the only way I could really hear what people felt they experienced was to invite them to talk and for me to listen. In others words I had to gather my data first hand. This was

undertaken using semi-structured interviews with families/carers and staff relating to their accounts of suicide in a mental health service. Grounded Theory provides an ideal opportunity to build in aspects of researcher reflexivity into the research, as part of the inductive nature assumes an openness and flexibility to following leads gained from the analysis of the data. I anticipated that the interview process would provide the opportunity to explore gently the experience of the suicide of a patient receiving mental health care and the experience of offering/receiving aftercare. My attempts to gather information using Grounded Theory aimed to achieve:

“Accounts that were conceptually rich, dense and contextually grounded”
(Pidgeon & Henwood, 1996, p. 78).

Simultaneous involvement in data collection and analysis offered the potential for analyses to emerge and shape the process of data collection, thus permitting the pursuit of topics explicit in one interview or observation but remain implicit or absent in others (Charmaz, 1995). As previously stated, this research was designed out of an interest in listening to people’s accounts of their experiences. Ultimately with the main aim being:

“Listening to people’s stories, whilst remembering the need to remain empathic, unpack meaning and actions to search for implicit meaning.”
(Charmaz, 1995, p. 55).

Charmaz urged the researcher to pay attention to what is spoken and unspoken by the participant, and emphasised the need to explore beyond what is expressed:

“Participants’ stories are more likely to hint rather than proclaim; foreshadow rather than foretell. Indeed to grasp the larger story it may be necessary to remain silent otherwise we may not discern or understand our research participant’s silences. We must look as well as listen to discover glimmers of the unknown as by doing so researchers enter the experience and sense or share the actors’ meanings” (1995, p. 323)

Charmaz refers to this area of research as a ‘liminal’ place, where the unexpected occurs, where stories lose coherence and speech neither captures nor conveys meaning, but must somehow be listened to and attempts made to understand.

3.5 A systemic and relational study

Throughout this research I have attempted to work systemically and be ever-mindful that suicide and trauma are often linked. Therefore the importance of

undertaking and building relational aspects into this study required a method and design that mirrored systemic practice. As discussed in the literature review, it was important for me to appreciate divergent views about death, suicide and trauma, including systemic approaches, for example McGoldrick et al (1992) and the four quadrants of visible-invisible, voiced-unvoiced, as described by Burnham (2012). NICE recommended 'watchful waiting' for people who had been exposed to trauma (NICE 2005). Indeed, as Krause (2012, p. 26) has highlighted:

"Viewing reflexivity through culture alerts us to similarity between ourselves and our clients ... constructive communication is only a possibility if we are able to acknowledge perspectives other than our own".

However we are all human and when suicide occurs during an episode of care and treatment it presents profound ethical, legal and spiritual challenges. As a clinician (and human being) I therefore needed to be aware of the potential impulse to "rescue" whilst also giving careful thought to the best timing, if indicated, for responding to requests for professional involvement (Shachar, 2010).

3.6 Family Therapy and connection to this research

Academic research is a serious undertaking, but this does not mean its methods and results should not be questioned. To overvalue this kind of knowledge would be to stifle curiosity. What the qualitative systemic research approach offers are alternative ways and perspectives of viewing systems, families and organisations, which are ultimately unending and dynamic.

Embracing the multiple possibilities of working with others when invited into their world, and utilising the skills and techniques of attending, listening, engaging and intervening is the life blood of family therapy. This form of therapeutic practice also often feels like a privilege.

I am reminded of the words of Lyn Hoffman:

"Family therapy as a braided Easter bread or Challah, with strands from early on disappearing and then reappearing in a changed position or on another side. Each new strand suggested an answer to a question that had been brought to the fore by a previous one. However it was the continuing conversation between the strands that made the entire braid so special" (Hoffman, 2000, p. 6)

In terms of family therapy literature one is spoilt for choice regarding what to elaborate and what to omit; however my commitment to a social constructionist view of the world seems particularly important, meaning:

“Rather than attributing the source of the pattern of a behaviour to an individual with what may be regarded as their ‘internal’ constituents of personality, attitude, emotional state and the like, my preference is to take the view that the sense one has of oneself, who we are and how we behave, results in part from the position we choose or are given within a range of discourses that society offers us” (Campbell & Groenbaek, 2006, p. 10)

The social constructionist world view, blended with positioning theory (Campbell & Groenbaek, 2006), further enriches the concept of the braided challah (Hoffman, 2000) and beautifully brings together how I see family therapy in connection to this research. That said, the NHS is a huge and vastly complex organisation that delivers services to a wide range of people with highly complex and diverse needs.

Reflecting upon what positioning theory tells us about the way individuals behave depending on the positions offered or chosen by them, invites questions regarding the what, where, when and by whom they are offered support within the NHS. Whilst my position to the subject matter may be familiar, having been employed by this organisation for nearly 40 years, this research has entailed me taking a step back to consider my position as a researcher. Irrespective of what stage of life we have reached or what the illness is, currently NHS services are available to all British citizens. We are truly fortunate in the knowledge that should we fall ill, we will be cared for no matter what. However, support after suicide is patchy and determined by the availability of services closest to the family in question. As discussed within the literature review, whilst standards and protocols for practice seem to exist for almost every eventuality in the NHS, how commissioners, managers and individual practitioners interpret and deliver these services sometimes appears arbitrary. This research has been born out of a desire to find out more about what happens when people are in need of this kind of help, and how services can be improved.

3.7 Evolution of the research design

Having considered the epistemology and methodology, I will now move on to research design. As mentioned earlier, in my NHS career I have been in positions of managing services as well as delivering clinical care at different levels of seniority/inferiority. My personal experiences and that of my family

members receiving services has been variable and in my view was largely determined by the quality of the relationships between patient and staff. This interest in relationships motivated me to undertake research within the qualitative tradition, specifically grounded theory and social constructionism, because it questions 'taken for granted knowledge' and invites us to be curious about the world and ourselves in it.

As mentioned earlier, demographic statistics have been collected about patients who commit suicide. Literature tells us of the suffering for family/carers connected with the person and that people bereaved from suicide stand an increased likelihood of complicated bereavement and the possibility of developing mental health problems. The literature also highlights the impact of patient suicide upon staff members, which I have studied previously. Consequently national and local policy is beginning to guide what organisations need to do after the death of a patient. However, little information of a qualitative nature appears to exist about what help family members and carers would like from the mental health service when the suicide of a relative occurs. I wanted to try to address this gap by listening to people who had been most closely affected.

4. Method and design

4.1 Introduction

In this chapter I will begin by setting out the aim of the study, then I will move on to discuss the process of research design:

- Selection of participants and inclusion criteria
- Approaches to participants and recruitment
- Process of interviewing, including reflexivity
- Ethical processes

This research was designed to undertake a systemic exploration into the experience of the support offered to family/carers by mental health staff after a relative has ended their life whilst receiving mental health services. This study has involved three main lines of inquiry.

1. To determine retrospectively from a sample of staff what support was offered by/ to family/carers after the suicide of their relative

- How the staff felt they managed this task
- What support they required to do so

2. To determine retrospectively what support and information the family/carers received from the mental health service at the time of the suicide

- What the family/carer thought of what they received
- What they felt would have been useful

3. To present the results of this research to the mental health service, to enable further development of guidelines for family/carer support. It is envisaged that part of the guidance would be suggesting and including ways to help equip staff to undertake this process more effectively, thereby improving what could be offered to families and carers. The methodology guiding this research was set out in the previous chapter, with the aims stated above.

Now I would like to describe the details of the method and design with the two groups of participants.

- a) To recruit a selection of staff from the mental health service, and by using face-to-face interviews, ask them what it was like to inform the family of the death of their relative, what support they offered to the family/carer, how they knew what to offer and how this was received.
- b) To recruit family members/carers who have experienced the suicide of their relative whilst receiving mental health care services, and gather information by face-to-face interviews about their experiences, including: how they were informed and what support they received. I will be asking about what contact, information and help was offered and whether the intervention was experienced as helpful or unhelpful. I will also ask about what family/carers might have expected or wanted from the mental health services.

Prior to and after the information was gathered, records, diary notes and reflections on supervision were made. This was followed by analysis.

4.2 Study participants

Information was collected from two groups of participants. The recruitment of each differed somewhat and will be discussed later. Firstly I would like to present the process as it related to the staff.

The aim was to recruit mental health staff with a mix of age, gender, professional background, years of experience, seniority, etc. that had management and clinical experience of working with patients who had ended their life and had been involved with the process of communicating and supporting family members afterwards. Due to concerns about the potential for staff either to be experiencing symptoms of PTSD/mental health symptoms for a year or more (NICE, 2005), or be subject to a complaint or litigation claim, it was important not to approach staff too soon after the experience.

Potential participants were identified through the Trust Serious Untoward Event Review team and myself. My previous research on the impact of suicide provided a really useful foundation for thinking about recruitment. I attempted to gather information about how this went, whilst also inquiring about what the team may find useful to equip staff with in future.

4.2.1 Inclusion criteria, recruiting method, responses and demographics

We identified 6 participants from staff group, with a maximum of 8-10 as stipulated by the Ethics Board. However if responses exceed numbers then it was agreed that I would interview participants nonetheless. In accordance with the research protocol (Appendix 1) email invitations were sent one at a time. All staff members approached responded favourably apart from one senior manager who did not respond either way. A further approach was made by me, however this was met with no response. The precise reason for the non-response is not known, apart from some anecdotal information I learnt about some difficulties in the manager's personal relationships, physical illness and a suicide attempt.

Burr (1995, p. 90) suggests:

“People who successfully warrant voice do so because they are adept at using warranting conventions. Hence those who are skilled “discourse users” have at their disposal the means to bring about their desired identity construction for themselves and resist those offered by others”.

Figure 4 Demographics of staff participants

Identifier	Gender	Role	Years /experience
Zoe	Female	Senior manager	25+
Yvonne	Female	Senior manager	30+
Keith	Male	Senior clinician	29+
Will	Male	Senior manager	30+
Vic	Male	Senior manager	20+
Tina	Female	Senior clinician	20+

4.3 The semi-structured interview

Having obtained consent, arrangements were made by email, telephone or letter for the staff to meet with me. The interviews were semi-structured, as I anticipated this process would provide me with an opportunity to explore what was meant by some of the feelings and experiences staff members reported.

I utilised an interview schedule (please see Appendices) to help guide my thinking and inquiry, which was initially piloted with a member of staff and

refined following wider discussion with clinical colleagues. The themes of inquiry developed and were taken from a combination of systemic, social constructionist theory, which guided my individual style. Several conversations took place with others in the clinical field, including systemic supervision sessions. These were influenced by my experience as a clinician also. The perspectives of other clinical staff were vital in attempting to harness current thinking; however what I myself brought to the study was also an important addition. I was curious to explore whether there were any particular attributes or qualities that stood out in terms of what motivated people to come into the field of mental health. Furthermore I was interested in the values and beliefs that clinical staff had about mental health care and the people accessing services.

Within this line of inquiry I was keen to find out about the philosophical and ethical standpoint taken by participants, which I hoped would lend itself to the social construction of meaning, as discussed in Chapter 3. Another theme explored was the staff member's experience of hearing the news of their patient's suicide. As this area was highly delicate, and accessed potentially troubling emotions, particular attention was given to allowing them time and for the careful phrasing of questions. Here I recalled my experience as a systemic practitioner and researcher, which I liken to Burck's (2005) argument about the importance of clarity as both a clinician and researcher. Exploring themes with staff members about what kind of relationships they had with bereaved family members and carers, I was mindful of circularity, neutrality and curiosity (Cecchin, 1987), as well as 'interventive interviewing' (Tomm, 1987). Here I was not only interested in whether there was a relationship, but also details about the quality of that relationship.

For example, I asked:

"What was your relationship like with the client and their family?"

Followed by;

"How was it decided that you would contact the family?"

I anticipated this would lead to them exploring how the decision was made, and by whom. Within this theme I was curious about how the mental health organisation undertook the process of responding to and supporting them, and whether it was the same or different for each case. I drew on positioning theory

(Campbell & Groenbaek 2006; Partridge 2007) to think about positions within the organization, how they were taken up or allocated in this respect. Additional exploration included asking what it was like to make contact, whether face-to-face or by other means like the telephone, and how this went, which again could have potentially accessed difficult emotions:

“Can you tell me something about how you felt when notifying the family/career about the death?”

I was curious to hear whether there were particular words or sentences that the staff used;

“What do you recall about what you said to the family/carer at the time?”

I invited the staff member to talk about what they said or did that felt positive and supportive, as well as what they would have liked to happen, perhaps done differently and ways the whole process could be improved. I wanted to find out about the help and support staff members offered to the family or carer at the time:

“What did you say to the family about who to make contact with afterwards if they need support or information?”

Also I listened to the staff member talk about the help and support they themselves received (or not) from the mental health service.

“Did you receive any support with doing this, at the time or afterwards?”

4.3.2 Collecting the data: interviewing staff members

Each staff member was interviewed in a location that was convenient to them, mostly at their workplace. The interview of between one and two hours was audiotaped on a secure encrypted device. In line with protocol, issues of confidentiality were adhered to. NICE (2005) guidance cautions about the potential for re-traumatisation after experiencing distressing events. Within the process of interviewing clinical colleagues and staff members I sometimes adopted an approach described by Dunleavy (2003) as “Constructive awkwardness” which enabled me to confront and challenge whilst keeping relationships intact.

Indeed within the process of interviewing colleagues, as Fredman (1997, p. 11) asserts:

“Professionals describe beliefs reinforced by training ... and often report their personal feelings contradict their professional beliefs. When working with clients helping professionals commonly explain they promote their professional beliefs, therefore it seems professionals have been encouraged to suspend, in favour of their professional beliefs, the rich variety of ideas they might bring to their relationship with clients.”

Ultimately my main objective was to listen to people's stories, whilst remembering the need to be empathic, as only then would I be able to find what was implicit in the explicit meanings and actions (Charmaz, 2006). This reminded me of what Sools (2012) refers as the concept of the performative effects of research, representation and authorship in narrative research. The interviewing of participants, collecting memos and recording reflections within the journal, which all warrant value from a slightly altered perspective, seemed to me to resonate with ideas from Sools (2012) who argues that the interview itself constitutes a 'big story', whilst the ongoing conversations in everyday life and interaction, which naturally occur between equals, provides 'small stories'. This is discussed further in Chapter 5.

4.3.3 Transcription and moving to early analysis

I transcribed each audiotaped interview, paying careful attention to altering names and any other identifiable information. This process was difficult and at times intensive, however it enabled me to really grapple with every word, and therefore I developed a great familiarity with the data. Each participant was sent a copy of the transcription and invited to add comments, alter or amend anything which they were not satisfied with. Little of the transcriptions were altered by any of the participants. Only after comments were received from the participants did I start the process of analysis proper. This is discussed more in Chapters 5 and 6.

I transcribed each audio taped interview myself. There is debate about the benefits and shortfalls of verbatim transcription (Halcomb & Davidson, 2006), but I felt this approach helped me connect with both staff and family members who had participated. Reflecting on the transcription process was crucial as it was important to be aware of what Oliver et al. (2005) refer to as 'vocalisations

and non-verbal interactions'. For example, in the course of conversation non-verbal communications, such as smiling and hand-waving commonly arise, as do verbal utterances like laughter or stuttering.

Being the person who interviewed and transcribed was important, particularly in the field of suicide research, when in a number of the interviews, words were accompanied by laughter or silences. Whilst some things remained unclear and a conversation is never experienced the same way by two people, only by being present could I be aware of the context within which it was said, and therefore what may have been meant by the communication. Much time and energy was invested in the process of transcription, however I was assisted and guided towards by McLellen et al. (2003, p. 65):

"At some point, a researcher must also settle on what is transcribed".

4.4 Sample of family member participants and inclusion criteria

In this Group, 5 participants were sought, as stipulated by the Ethics board, with a maximum of 8-10, on the understanding that anyone willing to participate would be interviewed.

Selection of the research participants began by obtaining a confidential list of all cases being cared for by the mental health service where a suicide had occurred in the 12 months before the start of the study. The total number, as determined by Her Majesty's Coroner, was approximately 15 people per year. Exclusions included those families/carers seeking legal recourse from the organisation, or those who were known to me as a clinician.

The aim was to obtain a sample of self-selecting participants that might be prepared to undertake a face-to-face interview. Consequently the sample was designed to be purposive, as it deliberately constituted non-random sampling (Bowling, 1997). By interviewing all who gave permission, even if their interviews were unused, the potential was built into the protocol that if the number of participants fell below 5, then an approach could be made to others.

4.4.1 Recruitment approach and response from family members

In accordance with protocol, having confirmed appropriate permission from the mental health service, a sensitively worded letter was sent to set out the aim of the study and enquiring whether the family member (s) would be willing to be interviewed. The board of ethics stipulated that the letter should be sent from a

senior representative from the mental health organisation and this was duly undertaken by the Medical Director. In addition the Ethics Board emphasised the requirement to approach one person at a time and await a response before moving on to the next. One positive response was received. Five invitation letters received no response with no feedback provided, therefore it was not possible to know the reasons. The possible reasons for a poor response rate was discussed with the family members first to be interviewed. It therefore became necessary to reconsider the approach being taken towards recruitment of family members, discussed in 4.4.2.

4.4.2 Family interview schedule, including consultation and piloting

Developing the interview schedule entailed delicate preparation, which included joining and consulting with two carers participation groups, in addition to meeting with a 'lay person', who had experienced suicide of a sibling, and generously made themselves available to discuss and reflect upon the content of the themes of inquiry. When discussing the subject matter with these people I discovered that they had strong opinions. First I was politely informed that suicide was the last thing family members and carers wished to contemplate, particularly with regard to their nearest and dearest. However, there seemed to be a consensus that more needed to be done to understand the impact of suicide on this group. These views were echoed within discussion with a 'lay person' who had made themselves available to share their own personal experience of the suicide of a close family member. Having discussed with the two groups and lay person, initial themes for inquiry seemed to emerge around what actually happened to the person who ended their life, after first spending some time thinking about that person in the context of their family. I was mindful of the sensitivity of the subject and therefore the caution required when entering into this discussion with people who may also be mentally unwell themselves. I was also mindful of my own anxiety, and how that anxiety may push me into broaching issues too quickly before having tried to establish some sort of rapport. The experience of having met with the members of the carers participation groups was helpful in guiding me along the way, combined with theories of systemic practice and my experience of working within mental health.

Acknowledgement of my dual position of clinician and researcher was crucial, as mentioned earlier. I had reflected about and to some extent anticipated the

possibility of being held accountable; to be invited to take responsibility for what had happened, indeed ultimately to feel blamed. The temptation to take things personally required me to reflect long and hard on my theoretical understanding and knowledge about social constructionism, positioning theory and systemic practice, discussed in depth later. Through the interviews I was keen to find out the extent to which the family members had been involved and included in the care of their relative; hence themes emerged to help navigate these areas:

Did you know what care your relative was receiving and what this actually entailed?

I was also interested to hear what family members felt about the care being offered to their relative and the kind of relationship the family had with the people delivering that care. Whilst all information was important, discussion of these themes, it seemed to me, would provide a lead into the crucial theme of inquiring about how the family were informed of their relative's death and what they felt about the way it was handled. I anticipated essential information would follow about what family members would have received in terms of support from the mental health service and whether they would have wanted something different to happen. Whilst the central aim of this study was to gather information from family members to find answers to the research question in mind, again the process of the interview provided opportunity for 'interventive interviewing'. As Tomm (1987, p. 167) put it:

"Reflexive questioning as a means to enabling self-healing".

Once the themes were identified, the questions within the interview schedule appeared to naturally emerge based also on discussions and reflections with others, including supervisors and research colleagues. In terms of possible explanations for the poor response rate of family members/carers, the first family member interviewed, for example, told me she very nearly put the letter in the bin, because of its official appearance, until her daughter suggested participating might be worthwhile. It therefore became necessary to reconsider the approach being taken towards recruitment of families; however initial changes of sending a less formal letter did not elicit any further responses.

4.5 Revisiting the research proposal and the Ethics Committee

In accordance with the protocol and eligibility criteria, the mechanism for approaching research participants adhered to resulted with only one family agreeing to participate. This was insufficient in terms of the viability of the study.

The important feedback from the first family member assisted me in thinking about other possibilities to recruit. My proposal was revised and resubmitted to the Ethics Committee. Unfortunately however new approaches yielded no results. With the appropriate permission, a further family member was approached through negotiation with a charitable organisation, and resulted in a member of a second family agreeing to be interviewed.

4.6 Family members who participated

Family 1 provided two interviews which consisted of two different family members being interviewed together on two separate occasions. Family 2 provided one interview about two suicides. Names have been changed to protect confidentiality.

Figure 5 The Bond Family (1)

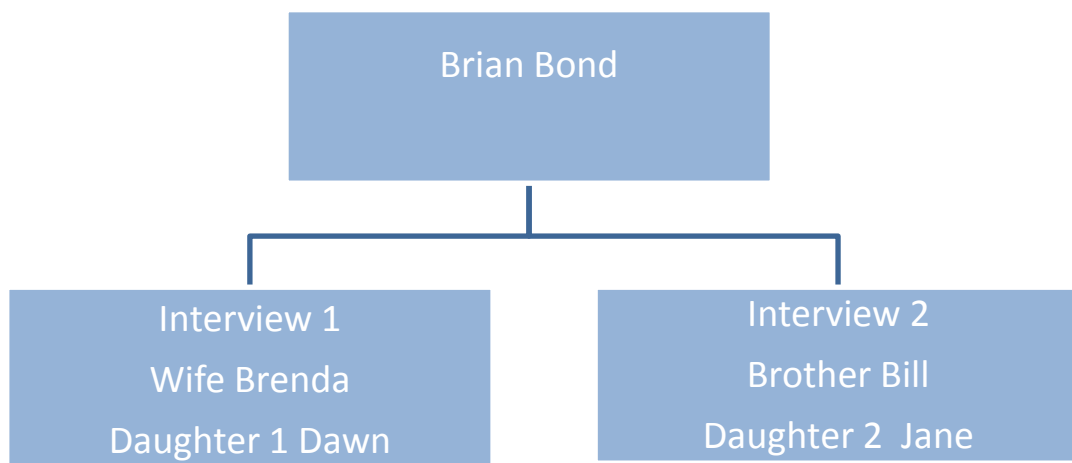
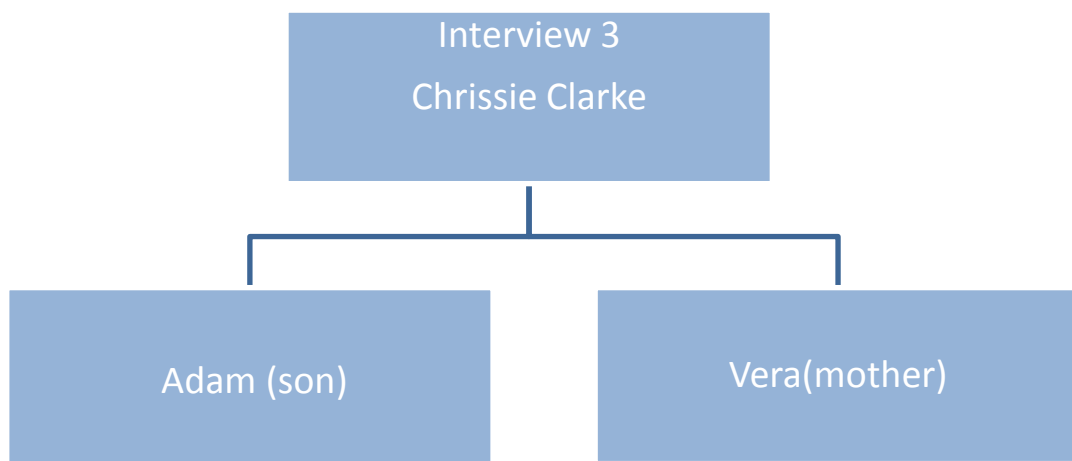


Figure 6 The Clarke Family (2)



4.6.1 Interviewing the family members

As with staff members, semi-structured interviewing was used to collect data. The interviews were audiotaped and notes were taken during and afterwards. I conducted the semi-structured interviews using an interview schedule, which allowed amendments and additions to be made if indicated by the Ethics Committee. In accordance with a grounded theory approach, this provided the opportunity to listen to family members talking about their experience and explore these in the moment. The interview schedule is included in the appendices.

I felt it was important for the family member(s) to determine where the interview would take place, in their own home or another location, for example, NHS premises. There was the option for the family member/carer to have someone with them, allowing for consent/confidentiality protocols. If at any time the family member or members wished to discontinue the interview this was to be respected.

Each interview took place either in their own home or, in the case of family 2, in the back seat of my car. Whilst it did not seem ideal to interview a participant in the back of my car, this was something the family member wanted to happen as other venues were not open to them. Interviews lasted between 90 minutes and two hours and were audiotaped. Notes were made during and after the interview. Transcription followed which was forwarded to the participant to read, check and amend as they felt appropriate. During supervision sessions I explored the process of interviewing and considered how questions might be posed. These thoughts were recorded in memos, diary entries and field notes along the way.

4.7 The role of the interviewer as researcher including reflexivity.

Being both a researcher and employee of a mental health service, although I had not been involved with providing care for the families I spoke to, the potential for defensiveness to creep into my communication was reflected upon and prepared for. I stated clearly to the family members that whilst I was an employee of the service, I did not know their relative personally and was keen to acknowledge the tragedy for both the family and the organisation. I found it helpful to have prepared some scaffolding statements, for example if I became anxious or felt like I was being 'put on the spot'. I tried to remain calm and remind the family I did not know their relative personally but wanted to try to find

out from them what might have helped. A colleague also kindly agreed to do a mock interview with me to help with preparation.

As part of the process I offered my condolences, which for me felt the right thing to do and embraced the theory around 'Being Open' (NPSA, 2005; 2009).

However because I was familiar with the subject matter, I considered the nature of my attraction to the subject. I wondered if by researching the subject there was something I was trying to transact. I remain uncertain about this still but continue to experience a strong pull towards the subject.

As Finlay (2002) suggests reflexivity in qualitative research involves the engagement of the researcher in self-aware meta-analysis. Self-reflexivity is woven throughout this thesis, which adds a further dimension to the multiple perspectives of suicide research, aided by a variety of approaches including use of the positioning compass (Partridge, 2007), which provided a means to dynamically explore and reflect on material being gathered by considering the polar opposite to enliven creative thinking.

4.8 National Research Ethics Service.

This research study received ethical approval from the National Research Ethics Service (NRES) Committee South West, Central Bristol. Approval was also received from the University of East London and the Research and Development department of the host mental health organisation. Potential participants were offered information about the study in the initial contact by email or letter. Relatives and family members were not asked to identify any staff members with whom they had had contact. Likewise staff were asked not to identify any families they had been in touch with. Therefore, for the sake of anonymity, families and staff were not 'paired'.

Recruitment of family members to this study proved very challenging. Clearly suicide is a distressing subject and mechanisms to protect people that may be vulnerable must be paramount. However it was important to gather robust and rigorous information. As suggested by Moore et al. (2013) there is no evidence that family members come to harm by participating in research about suicide. It may be said that by participating, family members are helped, through the belief that they are trying to make a difference for others. Research literature indicates that research into this area is worthwhile and often therapeutic to the family and carers (Dyregrov, 2003; Henry & Greenfield, 2009; Gibson, Benson & Brand, 2012 and Biddle et al., 2013). As mentioned in the literature review, the way

research is conducted and questions are asked in some part determines the results, however my stance supports the view that general statements are not taken for granted. Consideration was made regarding anxieties, perceived or real, about embarking upon research into this subject with the view that as long as the research is grounded in the ethical principles of human subject protection, ethical boards should not dictate the science (Moore et al., 2013).

As Lakeman & Fitzgerald (2009) point out, when conducting suicide research the researcher needs to have had experience working with suicidal people. Confidentiality, anonymity and trust are basic qualities crucial to any study, however in the area of a sensitive subject like suicide, even more so. Therefore anonymity and confidentiality were explicitly built into the consent form. Also assurance was made that potential participants would not be discriminated against should they require the mental health services. Indeed If at any time participants wished to discontinue with the research, this was respected. Collaboration and transparency was required between both the organisation and participants. It is important to note that staff members may have been open to criticism and legal proceedings by aggrieved family/carers. Despite being told we are to working towards a 'no blame culture' in the NHS, in reality a blame culture may exist which can be exacerbated by hasty actions after a high profile suicide (Sireling, 2004). Nonetheless by providing opportunities for non-judgemental questioning, reflection and disclosure, it was anticipated that honest feedback would be helpful to the bereaved family/carers and staff. This is akin to helping the unsaid become spoken, which may have provided some clarity to those affected (Rober, 2002; Burnham, 2012).

I needed to be sensitive to the fact that staff members who participated may have been grieving. There was also a danger that staff participants may have thought I was checking on the standard of care delivered. To obtain a willingness from the staff it was important for me to establish and state a firm position, to clarify and separate the research process distinctly from the organisational processes of the serious untoward event review. If distressed by the interview process, staff and family member participants were told they could access support from clinical staff.

4.9 Method of analysis

Grounded Theory was selected to analyse the data, as this involves the progressive identification and integration of categories of meaning from the face-to-face interviews. Grounded theory is both the process of category identification and integration. It offers guidelines on how to identify categories, how to make links between categories and how to establish relationships between them. Grounded theory is also the end product of this process as it provides an explanatory framework with which to understand the phenomena under investigation. Using this approach, I found the interview process presented similarities to systemic practice whereby I could consider with the family their beliefs, culture, actions and so on. Indeed this kind of reflexive research proved appealing because it mirrored to some extent the reflexivity inherent in good clinical work (Wren, 2004).

As mentioned in 4.4 and 4.8, the recruitment of family participants was extremely challenging therefore when I arrived to undertake the first family (Bond) interview I did not know that there would be more than one family member present. On reflection and taking into account my apprehension about the process, I did not think to consider whether it was acceptable to continue with the interview and I was not going to do anything to jeopardise this opportunity to listen to the family members talk about their experiences of losing their husband and father. That more than one family member, essentially the widow of the bereaved and one of his daughters, were willing to talk to me was viewed as nothing more than a gift.

Having used qualitative methods when doing research previously I was well aware of the benefits and good fit of using such an approach when researching sensitive subjects. However applying the grounded theory method with more than one person at a time posed some opportunities and challenges. Traditional grounded theory interviewing and data analysis with one participant is an intense process and gathers rich and profound information. With two participants being interviewed together, particular attention needed to be paid to this endeavour, which turned out to be a deeply moving interchange.

I was keen to carefully capture the information from each participant, which was something I had not done before in the research setting, although quite familiar with in the clinical arena. I recorded rigorous notes straight afterwards to

prevent losing important details about what had taken place, including my initial thoughts, feelings and responses to the process. I wondered whether I had attended sufficiently to each person and was conscious that I might have missed vital cues or opportunities to expand points or pursue alternative direction of conversation.

Consequently when transcribing the interview the participants were given a separate 'tag' to help clarify the information in the interviews, which was accompanied by notes about any non verbal details along the way. Indeed the second Bond family interview again consisted of two family members, the brother of the deceased and another of his daughters. Each was given a signifier to capture what they said. Data from the interviews was subject to constant comparison between each individual voice and the Bond family as a whole, by scrutinising the data and attempting to approach and explore the data by considering, similarities and differences including gender, culture and other alternative positions to what emerged.

For example the Bond family sample consisted of three women and one male participant. What the women said individually and then as a whole was compared with what the male participant said about their view of being involved, versus being excluded in the care of their relative by the staff caring for him.

The data seemed to reveal some subtle differences in that, whilst all the participants expressed feeling excluded and disregarded by the mental health staff, despite their grief and disillusionment, the female participants seemed to be able to try to appreciate and the challenges and pressures that the staff (and the NHS) were working with. Conversely the male participant appeared to remain resolutely and unrelentingly angry and bitter towards the staff. This evoked deeper analysis of how men and women experience and express emotion, which was further explicated as shown through the use of the positioning, compass (Partridge, 2007)

As Charmaz, (2006, pp108) guides, comparison of data helps to locate gaps and may find ways to fill them. This was something that during conversation with two participants became apparent, as they spoke together about their deceased family member and seemed willing and able to create together a sense of a coherent narrative about him. Furthermore by asking each family member questions about their relationships and memories they were invited to

locate themselves in time; in the past, present and future. This resonated with what is described as a 'liminal experience' and in some small way seemed to enable the family to speak thoughts out loud and look together at the history of their family going towards the future.

Further consideration of using the grounded theory approach when interviewing more than one participant is warranted however my view is one of having had the opportunity to gather, analyse and render data in slightly different ways as above, which I feel added to the overall synthesis and findings. I was not aware of occasion where grounded theory had been used with more than one participant at a time, Therefore the challenges included my apprehension about capturing as much as possible and the concern that I may miss important aspects or detail with more than one person to focus upon. Nonetheless the method afforded what I feel culminated in an authentic, flexible and productive means to an eventual profitable ending, namely the results from the study.

Grounded Theory was used to analyse the interviews however is more traditionally applied to one to one interviews. Whilst this theoretical approach provides the researcher with a wealth of opportunity to analyse the data, additional complexities are introduced in instances that involve more than one person at a time. Were this to be developed further, even more opportunities may be revealed to contribute to the methodology of research using grounded theory as a whole.

5. Analysis

5.1 Introduction

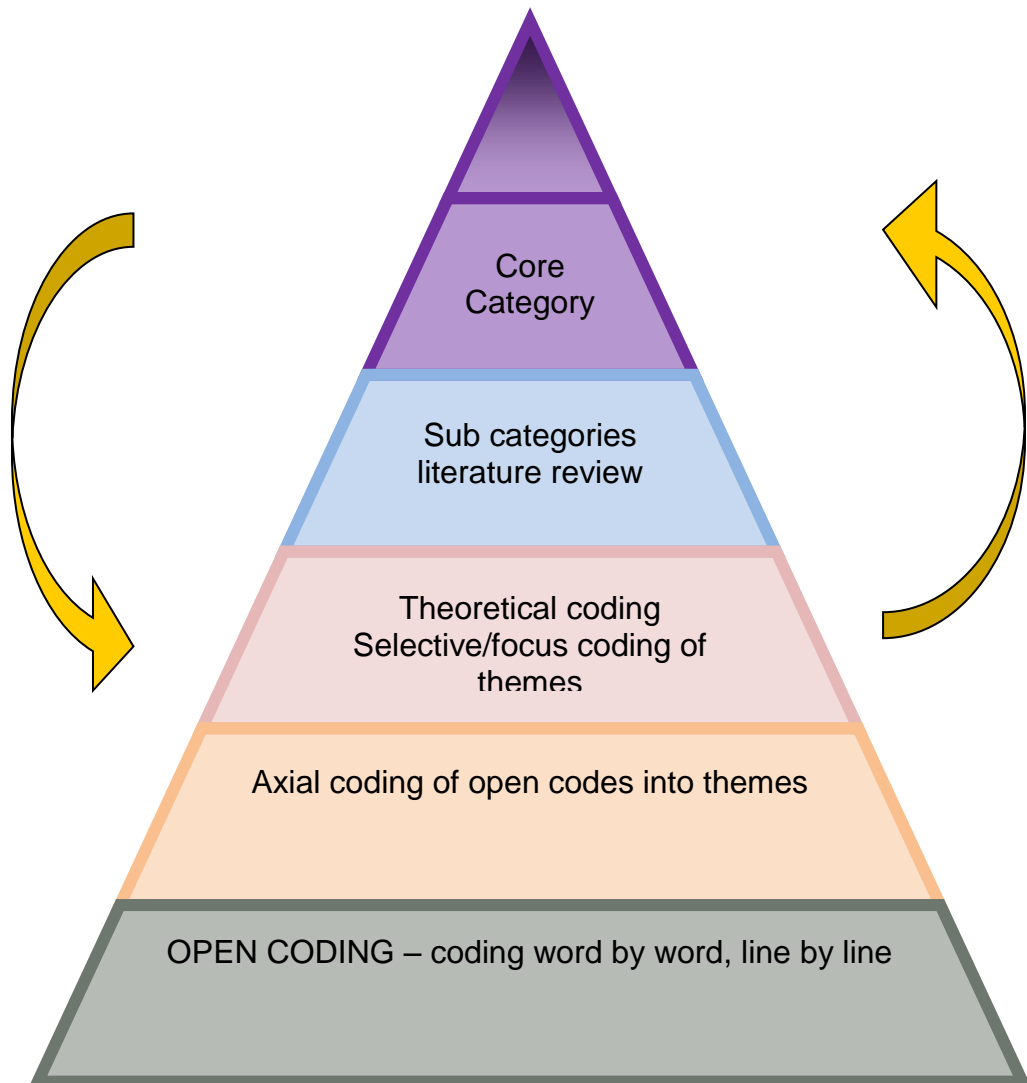
Chapter 5 is arranged in 5 sections. In Section 1 I discuss the analysis of staff member Zoe's data. Section 2 presents analysis of the staff member group as a whole. Section 3 shows analysis of the family member participants. Section 4 sets out the data across the family participants as a whole. Section 5 concludes with a summary of the analysis process. Pseudonyms have been used throughout.

5.1.1 The process of analysis and writing up

Describing the collection of data in a linear fashion was challenging, as it was a systemic and iterative process. I decided to select particular examples and track the process from early open coding by using a diagram, which I refer to as the 'research pyramid'. Please refer to Appendix 11 for the whole transcript. As the research process continues the analysis moves back and forth, which I relate to the research pyramid. I include excerpts of transcripts from the interview with Zoe, illustrating initial open coding, followed by axial coding and then more focused/selective coding. The levels of analysis from early stages through to higher levels of abstraction merge between levels continuously within the pyramid. To illustrate my thinking in light of different themes I have included extracts from my diary, field notes and memos. Then I have presented subcategories and core categories that emerged from the analysis. It has not been possible to include all my analyses of the data; however I have included graphs and figures to help describe the process throughout.

Taking a grounded theory approach to the analysis, I was faced with the issue of how to manage the increasing amount of data. Considering my individual style and skills as a practical and pragmatic person who prefers simplicity and possesses limited IT ability, I found that a colour coded research pyramid (Figure 7) suited my purposes well. This provided a system I could work with, whilst incorporating the influences that I needed to be conscious of along the way. Step 1 of the analysis is coloured grey, denoting early open codes; step 2 is orange, relating to axial and focussed coding; step 3 is pink, indicating theoretical and selective analysis. Finally the subcategories are illustrated in blue and then core categories in purple.

Figure 7 Research pyramid



The challenge here was not only representing a process that was fluid and evolutionary but also complex and involving a large amount of data. It was not a case of fitting codes and categories into one another in an arbitrary way, more a process of moving data back and forth between different levels of abstraction, as indicated by the arrows, so that I could constantly compare and contrast.

The transcript of the interview with Zoe, showing early analysis, appears in Appendix 11. In this section I describe detailed analysis of three subcategories: 'training needs to ...', 'emotion' and 'breaking bad news'. Here I was constantly looking for spoken words, comparing those that seemed to couple together and seemed to relate to one another. Charmaz, (2000, p 61) refers to this as an:

'Identifying moment',

thereby suggesting similar meaning in conversation or interaction conferring a significant identity upon another, as in focussed coding.

5.1.2 Step 1: Open Coding word by word, line by line

Beginning the process of initial coding consisted of reading and re-reading the transcript of Zoë's interview and studying the words one by one. I was ever mindful through the early analysis of the data that:

"Coding generates the bones of the analysis which then assemble into a working skeleton on which to build" (Charmaz, 2006, p. 45).

Figure 8 shows a section of Zoë's interview, which was the first in the research study and therefore very important in terms of assessing how the design would either work or not work. Just as a skeleton provides frame, substance and congruence to a body. One problem I had to consider was that the data was very familiar to me. As Charmaz (1995, p. 53) warns:

"The more familiar, routine are the events, the more problematic in creation of original conceptual analysis of them will be, therefore breaking through ordinariness of routine events takes effort".

I cannot recall the precise number of times I read and re-read the transcript, however particular words started to leap out at me: for example 'poor', 'dealing with' 'weighted' etc. These 'rich words' (Fredman, 2004) are highlighted in grey, to indicate the process of open coding.

Figure 8 Step 1: Open coding example in Zoe's transcript

Line	Zoe's interview transcript (Excerpt I)
56	Had training
57	That's been very poor
58	We've had lots of training over the years about how to prevent suicide
59	How to recognise the signs and
60	But actually there not a lot of training
61	On what actually happens ... when
62	And that's not just dealing with, with families
63	Its dealing with staff
64	It's dealing with other services
65	It's dealing with
66	Had some training on
67	Had some very good training on coroners courts
68	um but there isn't a lot
69	Seems to be weighted at the prevention end.

The data above began to set the scene for an initial code around a stated need for training (Open Coding Theme 1) and the preparation of staff charged with the delicate role of communicating with family/significant others after a suicide. Clearly Zoe was talking about the paucity of training. Her perception was that the training she'd had was 'weighted towards [suicide] prevention' as opposed to support in the aftermath of a suicide. As well as this perceived need, Zoe also talked about the multiple needs staff find themselves attending to, including those of the family as well as other staff in the organisation and other services.

5.1.3 Step 1/Step 2: Separating data fragments and moving towards codes

Through selecting, separating and sorting data in this way, I began to arrange the lines into a loose group around the early code of 'training needs to'. Doing this entailed taking a pair of scissors and physically cutting up chunks of the transcript, firstly in lines, then slightly larger pieces, determined by the central word or theme of the line or sentence. As Willig asserts:

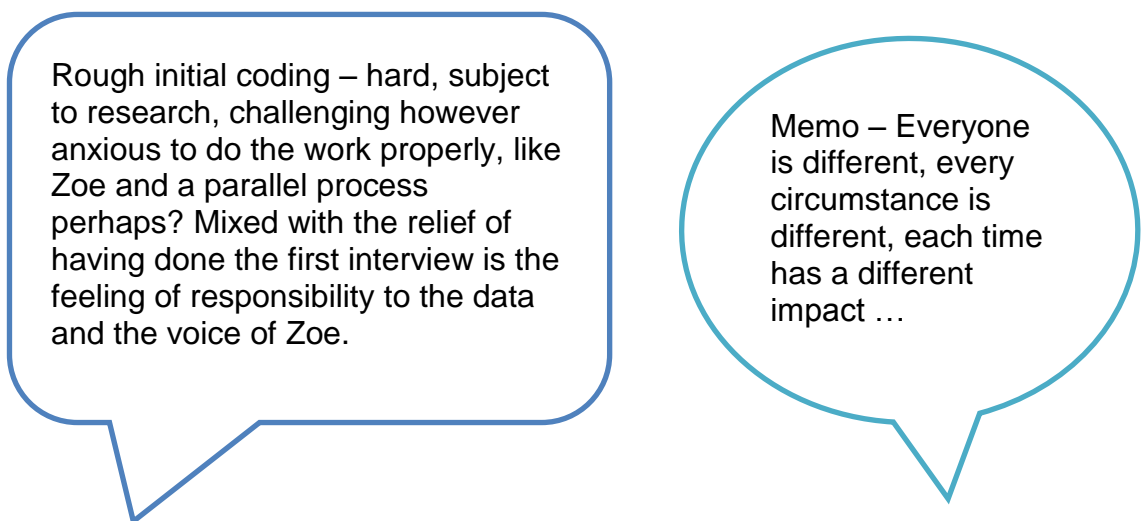
"The building blocks of grounded theory method start by looking at lower levels of abstraction or descriptive labels" (Willig, 2008, p. 30).

Accordingly fragments were selected and named, moving through levels of analysis from grey to orange, whilst blending memos and diary notes throughout. By referring to my notes compiled after the interview with Zoe, I was able to reflect further on her views regarding the feeling of being poorly prepared. I could also connect this to my impression of Zoe during the interview,

which was that of being impressed by her strong commitment to doing a good job. I felt humbled by what I was hearing. This information contributed to a growing group of fragments created out of the transcript, which as time went by amounted to hundreds. I was aware I needed to be able to continually view and keep in mind the emerging groupings but there were far too many to fit into a small area. I knew it was important not to be tempted to force the data into groups that might not fit.

To illustrate the process I include an extract of the diary notes I made at the time. Throughout I have included an amalgam of my field notes, memos and impressions and I include them alongside the analysis in blue speech bubbles to illustrate my workings.

Figure 9 Field note/memo 1



As the amount of fragments grew so did the search for space to lay out my data. I had to commandeer my dining room table which seats eight. This enabled me to spread fragments of data across all four corners, until each one seemed to sit comfortably in a group, although on some occasions I duplicated fragments as they appeared to belong in more than one place. This process of comparing and contrasting the codes took much time. The analogy I was tempted to draw was that of playing cards, in particular 'Happy Families' which, for those not familiar with the game, consists match cards together in the same family until the family is complete.

This method of organising the data introduced an element of playfulness into what was a serious, daunting process. For example the grouping of fragments

around the initial code of ‘training needs to ...’ To explain more about how I approached this, I include the example of the initial open coding of another transcript below (Figure 10) which shows Zoë’s description of her preparation and training for talking with family members after the suicide of a relative. This begins to provide more detail, not only about the difference and what might help or hinder, but also it introduces the view that each time the need arises to contact families:

“It’s like something completely new”.

Reflecting on my own experience of communicating with family members after the suicide of a relative, I thought further about the kind of training which might help staff, for the use of particular words and language. Indeed this theme became ‘breaking bad news’ (Open Coding Theme 2). Here Zoe says it’s something which has developed over time. She likens the relative to a

“guinea pig”.

Again to illustrate my thinking I include my diary notes/memos, alongside the figure.

Figure 10 Step 2 coding example in Zoe’s transcript

Zoe’s interview transcript (Excerpt II)	
78	It’s something you develop over time
79	And I think it’s hard to develop
80	Because you can develop certain skills
81	And you can learn from us how you do it but
82	But in, in a way the poor relative is a bit of a guinea pig
83	Researcher nodding
84	Because you’re learning from ... everybody’s different
85	every circumstance is different
86	Every time you’re faced with this it’s like something completely new
87	Because it’s very different
88	If there is a care co-ordinator there that’s worked with the family
89	That knows the family and is working with them
90	It’s easier to in a way break that news
91	But if there’s a strange [family not known] family
92	Who haven’t been happy with the services
93	It’s a guilt and blame culture there
94	That’s very different
95	Us, so it’s ... yeah it’s hard

Relatives of the deceased are seen as “guinea pigs” ... how must this feel not only for Zoe, but the relatives and what is their experience? On one hand Zoe felt ill prepared, on the other hand ... Guinea pigs, conferred with little intellect, are at the mercy of those experimenting on them.

My personal experiences of breaking bad news were contrasted with this data, which helped me think about the material in a different way, and further developed the code around the perceived need to be better prepared. Words about emotions such as ‘guilt’ and ‘blame’ heralded an emerging early code of

'emotion'. Coincidentally, during the process of this research, I was asked by my manager at the time to develop training for staff around 'Breaking bad news', which I adapted from Hart (2006). Later I will discuss the influence of this project on my thinking, however it felt important to raise here because of its relevance to the subject and the way that the initial codes from Zoë's interview were approached and selected. This clearly related to the development of the training I was compiling as well as the research analysis. 'Breaking bad news' became a substantive code, then a theme leading into subcategory and finally a core category, which I describe later.

Returning to the excerpts in Figures 8, 10 and 11 another theme emerged which later became subcategory 1, loosely titled: 'Training needs to ...'

This consisted of data illustrating the lack of preparation staff felt they had about communicating with others, including family members, and possible recommendations about ways staff could be better prepared. It seemed from Zoë's perspective that if a family member felt they had been included by staff in the care delivered to their relative, it may have been slightly easier to break the news. Zoe spoke about the different experiences of breaking bad news to families with whom she was more familiar compared to those she did not know. The unpredictability of this experience was also recognised and the fact that Zoe repeated the word 'blame', which offered one clue as to how staff members might have felt about not being well prepared. However, at this early stage of the analysis it was important to remain open-minded and to suspend my preconceptions about what Zoe was saying. As the reading and re-reading took place, it struck me that the words used when talking about conversations with relatives seemed to identify a desire in the staff member to find something positive to say, that might acknowledge the importance of the person who had just died. By this point in the analysis a number of themes were gathering significance.

5.1.4 Moving from Step 1 Open coding to Step 2 and 3 Axial, selective and more focussed coding

As the process continued I was reminded of Charmaz (2006) who urges the researcher using grounded theory to halt and pose questions of the data and consider which theoretical categories statements might indicate. Bearing this in mind I moved towards more focussed, selective coding as I was constantly comparing and contrasting the data.

Braun & Clarke (2006, p. 9-10) offer guidance about developing themes including:

“Capturing something important in relation to the research question, thereby representing some level of patterned response or meaning within the data set”.

The questions I posed were:

- What counts as a pattern or theme?
- What size does a theme need to be?

Searching for repeated words or phrases tended to indicate a theme, but I was also aware of the importance of less often repeated themes, and how they might be linked to main themes. I was urged to revisit my diary notes and memos which reminded me of the ‘braided challah’ (Hoffman, 2000) and the kneading of dough, the blending and the threading together of strands to form a rich and special bread. This concept seemed to sum up the ongoing process of data analysis and collation.

Having said that there is no hard and fast rule about what amount of data constituted a theme. Indeed Braun & Clarke, (2006) suggest that researcher judgement is necessary to determine a theme, thereby promoting flexibility and not being constrained by rigid rules.

Returning to Zoë’s transcript, codes continued to be joined with other codes, then developed into themes.

For example, in Figure 11 line 97 Zoe said:

“It’s a different set of circumstances each time”

which became an initial code, as did line 110:

“it’s a very different relationship”.

In line 114 Zoe added:

“you just don’t know the relative”

And then in line 115:

“you’ll actually contact someone you’ve never met before”

Memo extract – If the family are known & engaged are they more or less blaming? Deconstruction of engagement ... Quality of relationships.

Tension that exists between trying to do a good job but how challenging this becomes if consent is

Then in line 117:

“you don’t know their story”.

The extracts above show how the initial codes began to group around the early theme of what makes a difference to ‘breaking bad news’.

Figure 11 Coding example of Zoë’s interview transcript (excerpt III)

Zoe’s interview transcript (excerpt III)	
97	because it’s a very different set of circumstances each time
98	and each one of them had a care coordinator who interacted with the parents
99	the parents could see everyone was doing the best possible job
100	all working together
101	but despite all of our efforts
102	uh, uh, this happens
103	and there’s no blame
104	to the family or no blame to family or services
105	it’s a very different way than if someone who’s
106	hh hasn’t necessarily engaged
107	or the person hasn’t let us get engaged with the family
108	the family feel at odds because they can’t
109	they are trying to engage and we are being told we can’t tell things
110	it’s a very different relationship
111	sometimes you can feel there’s a blame culture going on and
112	and that’s a very different approach
113	and that’s a very different approach
114	you just don’t know the relatives
115	you actually, you’ll actually contact somebody you’ve never met before
116	who you don’t know before how they’re gonna react
117	you don’t know their story, if you like
118	and um and suicide is such a ... devastating thing

As Zoe provided more detail about what it was like to tell someone a relative had died, the initial codes in grey add insights into some of the relational aspects of the care being delivered; like whether or not the family were known to the services, which might make a difference to how breaking bad news could be approached. In my diary notes, memos, discussion with colleagues and supervisors I reflected on the difference it might make when a family is known to the team or worker, compared to one that is not well known. Then I posed the following questions:

- *Does the suicide of a stranger affect one differently to that of someone with whom you have built a therapeutic relationship?*
- *Does family inclusion and ‘all working together’ make a difference when a suicide happens?*

Posing such questions was an essential part of the analysis and invited reflection on relationships, both positive and negative. Whilst I certainly felt I

could answer these questions myself, now I could start to answer them from the perspectives of others. When connected with the literature the information created a growing sense of meaning which itself became established in the process. I also noticed that staff members might be ‘searching for resilience’ during conversations with family members. Another question I posed was;

- *Do staff members try to search for resilience?*

This emerged within Zoë’s transcript and signified the development of an important code which then became a theme. Zoe appeared to demonstrate and describe searching for strength or being in possession of ‘resilience’, both in staff members and others, including the families of the deceased. I will talk more about this code on page 108, Figure 23, as it became a category in its own right within the core category 3 of ‘breaking bad news’.

Zoe appeared genuinely interested in how people tolerated things that happen in life, including suicide, and spoke about her interest in people’s resilience, which led to the question:

- How do people tolerate things?

This was captured through a discussion about a young son who had not experienced a good relationship with his father for many years before his father ended his life, highlighted in Figure 12.

Figure 12 Coding example in Zoe’s interview transcript (Excerpt IV)

Zoe’s interview transcript (Excerpt IV)	
303	but their relationship had not been a particularly good relationship
304	um, and he had a young son who I phoned
305	um, and he had a young son who I phoned
306	I think this had been an ongoing thing for years and years
307	and actually his dad had actually achieved it
308	so it was out of the blue
309	um, and I did phone up

Intense relationships, what was it like feeling ill prepared – expectation for

As shown above, and reflected in my notes, when Zoe rang this young man she did not really know how it would go, which seemed to feed into a sense of not knowing how people will react when contacted by mental health services after a serious event like suicide.

This added to Theme 1, 'Training needs to ...'

Figure 13 Coding example taken from interview with Zoe showing open to axial analysis into theme 1. Training needs to ...

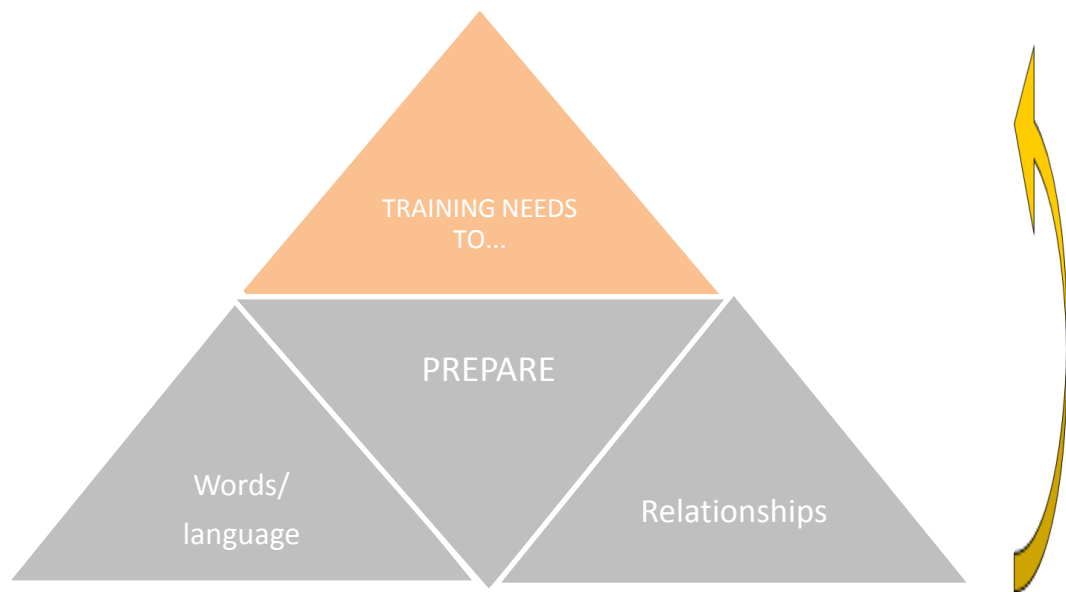


Figure 13 shows the two levels of analysis taken from the interview with Zoe, with the open codes of words and language highlighted in grey. Comparing and contrasting the data in Figures 8-12 led to the formation of the theme: 'training needs to ...' in orange, which correlates with the research pyramid in Figure 7. The analysis of Zoë and the following staff members' data, revealed comments about what they felt might have helped in the role of breaking bad news and/or supporting family members, carers or their colleagues. Suggestions for training and ways to prepare were offered by the staff members, which are discussed later.

As the data increased the themes and categories which emerged can be seen below:

Theme 1. 'Training needs to'....

Theme 2. 'Emotion'

Theme 3. 'Breaking bad news'

Theme 4. 'Relationships – Including families'

How these early categories became further built on and developed is illustrated later. To provide more detail I would like to describe what I did after the early coding of theme 2, 'emotion'. As discussed earlier, an important part of this research was to preserve the voice of the speaker, whilst also grounding the analysis. According to the research pyramid in Figure 7, during this process early codes moved between different levels of analysis in a 'see saw' fashion until they seemed to settle, from grey to axial codes/themes in orange, then to theoretical more focussed codes in pink and finally blue subcategories.

5.1.5 Step 4/5 Analysis of 'Emotion'. From a code, category to a Core Category (CC) 2

By taking examples of initial (grey) coding, where words like 'anxiety', 'fear', 'anger', 'guilt', 'blame' and 'sadness' were separated initially from the text, then moved around and coupled with similar codes of emotion. These were collated into descriptive labels of low level abstraction, which inclined themselves to be situated within the heading of 'emotion'. Because of the repeated use of particular words like 'blame' and 'guilt', and their relationship with emotion, early codes were amassed into the theme of 'emotion', which became, through constant comparison and further analysis, a subcategory (SC) in its own right.

This process was complex. My early analysis of words describing emotion were separately coded. As analysis progressed and further transcripts were subject to the process, the separate codes seemed disjointed and disconnected.

Reflecting on my memos and revisiting the literature of emotional talk (Fredman, 2004), I was reminded that one cannot assume a common understanding of emotion. Perhaps, as Fredman (2004, p. 7) cautions:

"Even when a word is used for an emotion, the same word may be used and understood in different ways to different people".

Reading and re-reading the transcript, and paying even more attention to the meaning created in the moment, led me to a consideration of shared language and meaning. I therefore reviewed my early approach of being reductive in terms of my understanding of 'emotion'. To explain this approach a little more: my supervisor asked me to consider the idea of packing my possessions into boxes, as if moving house. Of course this process consists of labelling items and boxes to facilitate a smooth unpack at the other end. However, I had in effect been labelling each item as if I were labelling each item of cutlery in a kitchen, whereas it might have been more prudent to label the box within which

each item of cutlery was to be stored. This approach led to me thinking differently about 'emotion'.

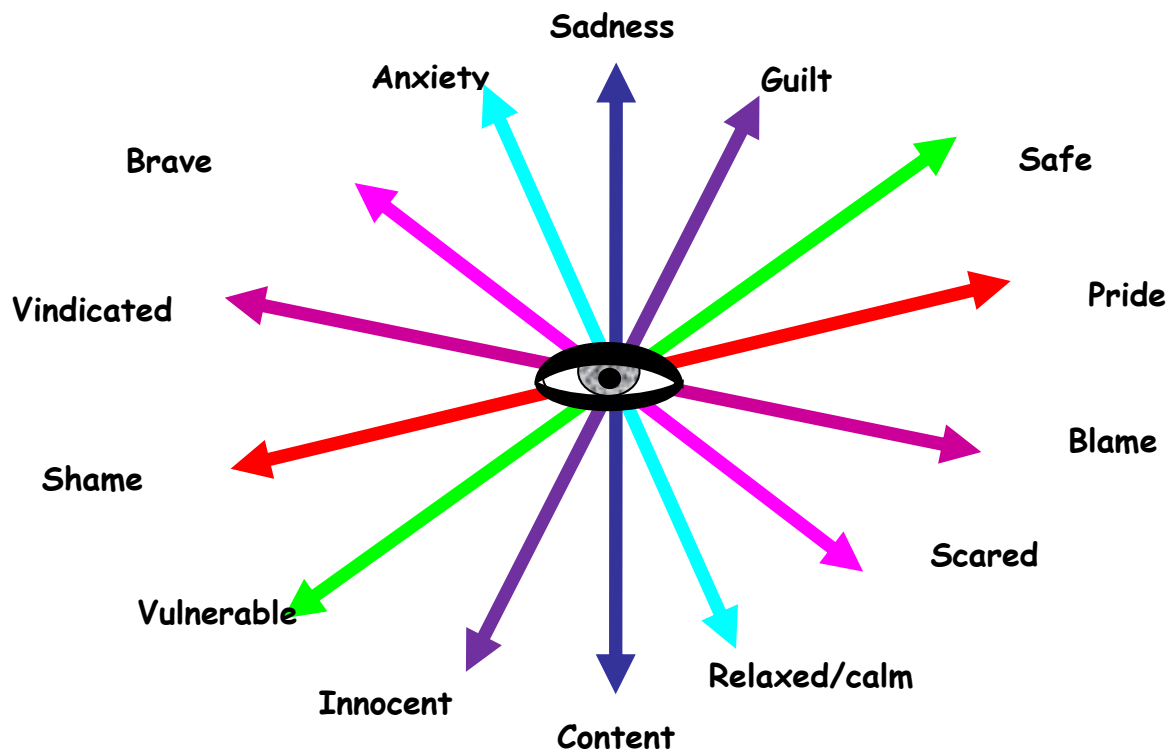
Therefore having initially broken down the transcript into line by line codes, I reversed the process and brought the codes back together into rough groupings relating to context. Having presented a piece of transcript and early coding at the research data analysis session with my peers and course supervisors, it seemed apparent that the experiences could be grouped into three areas:

- Experience of emotion in the context of staff receiving or hearing bad news
- Experience of emotion in the context of staff passing on or communicating/or breaking bad news to other staff
- Experience of emotion by staff in the context of breaking bad news to families

This process illustrates what Strauss & Corbin (1998) refer to as axial coding, which describes the strategy of bringing data back together into a coherent whole following the earlier fracturing through the process of the initial coding. By this means I was able to answer questions like: when, why, where and how? Having identified emotion in relation to different contexts, I wanted to examine and reflect upon the meaning more deeply. Essentially I was interested in hearing staff members say how they felt, for example 'anxious', when in the situation of either hearing or breaking bad news.

Returning to my diary notes and memos, whilst wondering and scribbling more memos to myself, I explored the concept of 'feeling anxious' and 'not feeling anxious' and experimented on how I might extend this further. Again posing questions led to ideas about how to work with the data in a different way, especially using the concept of sensitising (Kelle, 2005) which provides a general point of reference against which to test emerging data. I took advantage of what Partridge (2007) called the 'positioning compass' and applied this approach to considering the polar opposites to each named emotion. It is important to note the compass is not static, fixed or 'real', more a tool to invite viewing constructions at a point in time.

Figure 14 Emotion viewed through the positioning compass.

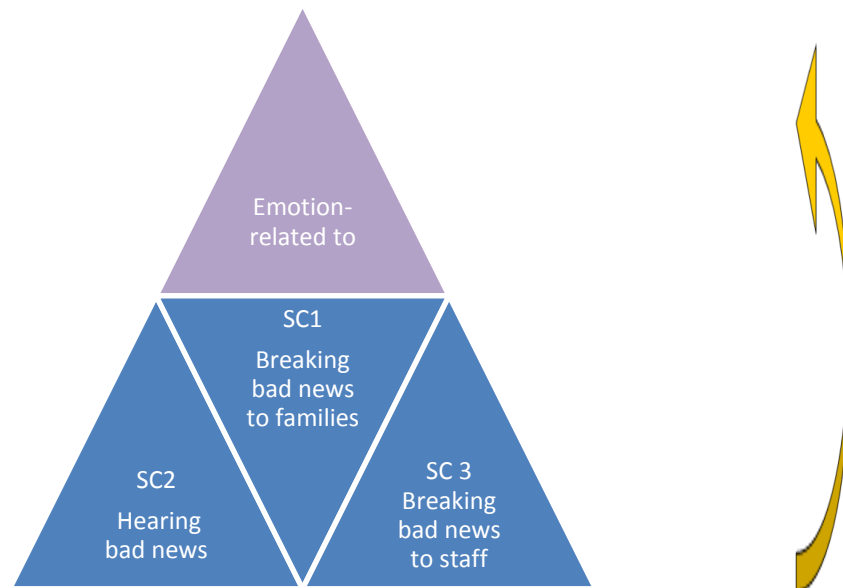


As a systemic practitioner I am not guided by ‘black and white’ thinking but by considering many points of view and thereby reaching a ‘middle ground’. This technique invited useful reflection in this area. Whilst reminded by Fredman (2004), Shotter (2015) and others, not to assume that I know what the opposite emotion might be, the compass invited me to ask how realistic it might be to feel calm and relaxed when hearing or breaking news about suicide? Likewise, feeling ‘scared’, as opposed to feeling ‘brave’, were emotions that could both be felt. By this means, to help my thinking, each label was subjected to consideration of the polar opposite. Consequently the theme of ‘emotion’, with smaller couplings around each label, took shape. It struck me that if the staff felt better prepared, having had training and support in dealing with and breaking bad news. Therefore I thought preparation through training about what they might expect to feel might be helpful. This linked to a theory of ‘Attunement’, whereby Shotter (2015) suggested approaches that could be useful when meeting with or contacting families:

“A framework of exemplary experiences that provide us with a structure of anticipations of what to expect will result from our actions within our living, responsive relations to our surroundings” (Shotter, 2015, p. 138).

Consequently I reviewed 'emotion' as a core category (CC), purple in the research pyramid, consisting of three main contextualised subcategories in blue with the arrow indicating movement of analysis.

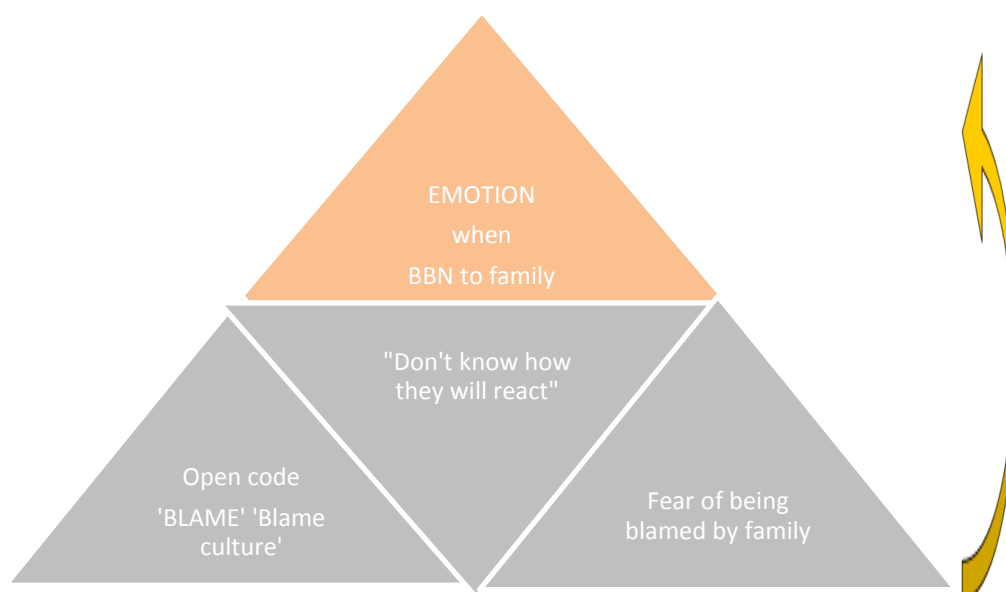
Figure 15 Subcategory 2. 'Emotion' showing construction from the subcategory into a Core Category



To describe how I got to this point I would like to return to the initial codes of emotion and, in the next series of figures, show how the analysis evolved.

Taking the example of "blame" as mentioned earlier, Figure 16 sets out this early coding. 'Breaking bad news' is abbreviated to 'BBN'.

Figure 16 Coding example from interview with Zoe showing open to axial coding into Theme 2: Emotion



This figure shows the movement as analysis developed in line with theorising and reflection, from grey to orange axial coding.

Figure 17 Coding example from interview with Zoe showing focussed coding of Theme 2: Emotion

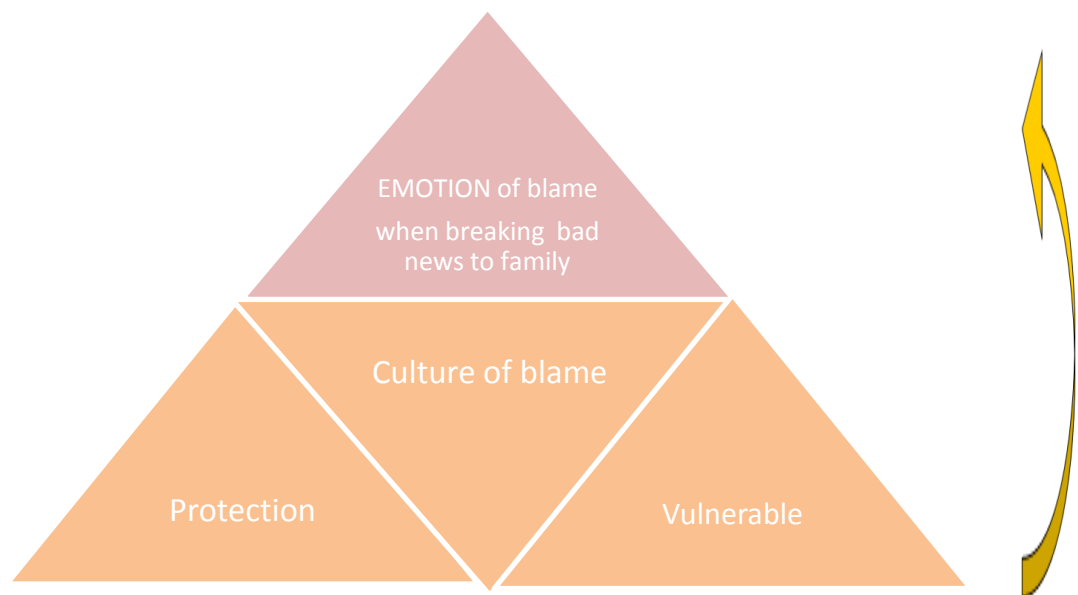


Figure 17 shows analysis of axial coding/themes in orange, to selective focussed coding in pink within each blue subcategory (SC) to illustrate the context of the emotion in SC 1 (Figure 18), breaking bad news to families.

Figure 18 Coding example from interview with Zoe showing focussed coding of Theme 2 into a subcategory: Emotion

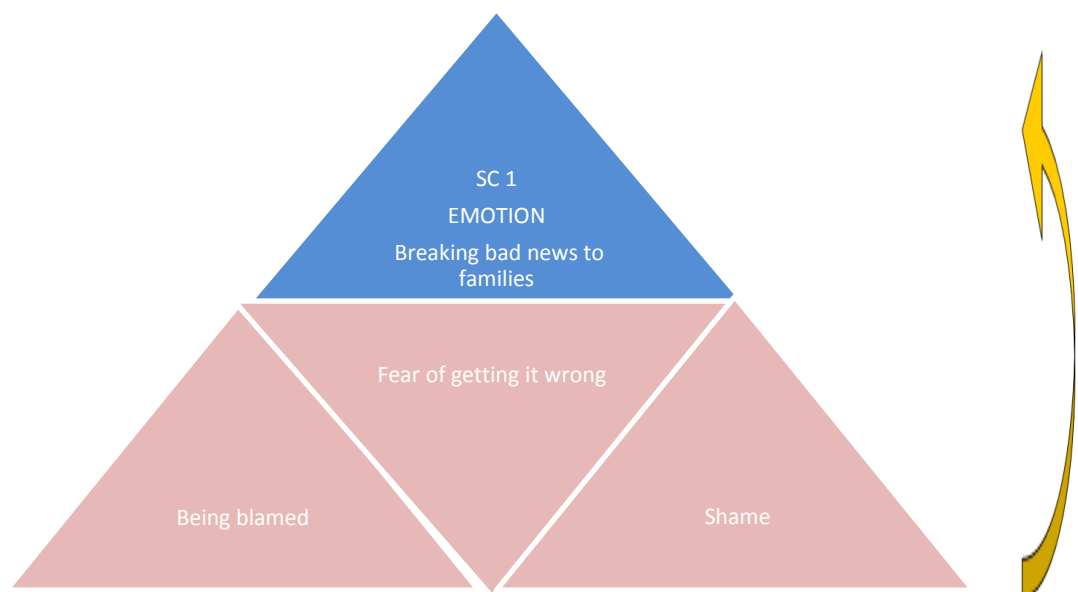


Figure 18 tracks the analysis of 'emotion', from the open code of 'blame' into a blue subcategory, showing how I arrived at the core category.

5.1.6 Step 5: Selective coding towards sub categories (Blue in the research pyramid)

At this point it is fair to say I was starting to see early initial codes taking shape, akin to the concept espoused by Charmaz, (2006, p.45) of the 'skeleton' which provides framework to the research. As time went on the increasing amount of codes, themes and categories residing on the top of my dining room table became difficult to manage. A solution availed itself by which I could manage the data, the use of labelled plastic pockets.

Out of this iterative process themes were grouped together, synonymous with the phase of axial coding and the precursor to selective or focussed coding. The table in Figure 19 provides some emerging codes and subcategories that after further analysis of Zoë's interview seemed to gather meaning and significance. This provided a richness of experience which helped me consider similarities and also difference in content. Although in no particular order of priority, the colour denotes level of analysis as consistent with the previous diagrams where subcategories are blue and the orange/pink represent lower levels of analysis. At this stage there were 5 subcategories; however, as time and analysis progressed some of the ordering altered.

Figure 19 Emerging subcategories

Level of Analysis	Evolving Subcategories				
Subcategory	Training needs to...	Emotion – hearing/ breaking bad news	Breaking bad News	Managers supporting, who supports them?	Formal processes
Selective, focussed coding of themes	Consoling others – Saying sorry	Use of words and language communication	Relationship and variation in reaction (depend upon relationship with staff?)	Legacy of suicide	Attending to multiple needs of others
	Resilience – how people tolerate things	What makes a difference? Help or hinder the process of supporting	Family 'at odds', turning help away	Mental health, illness and suicide	Including families in care 'all working together'




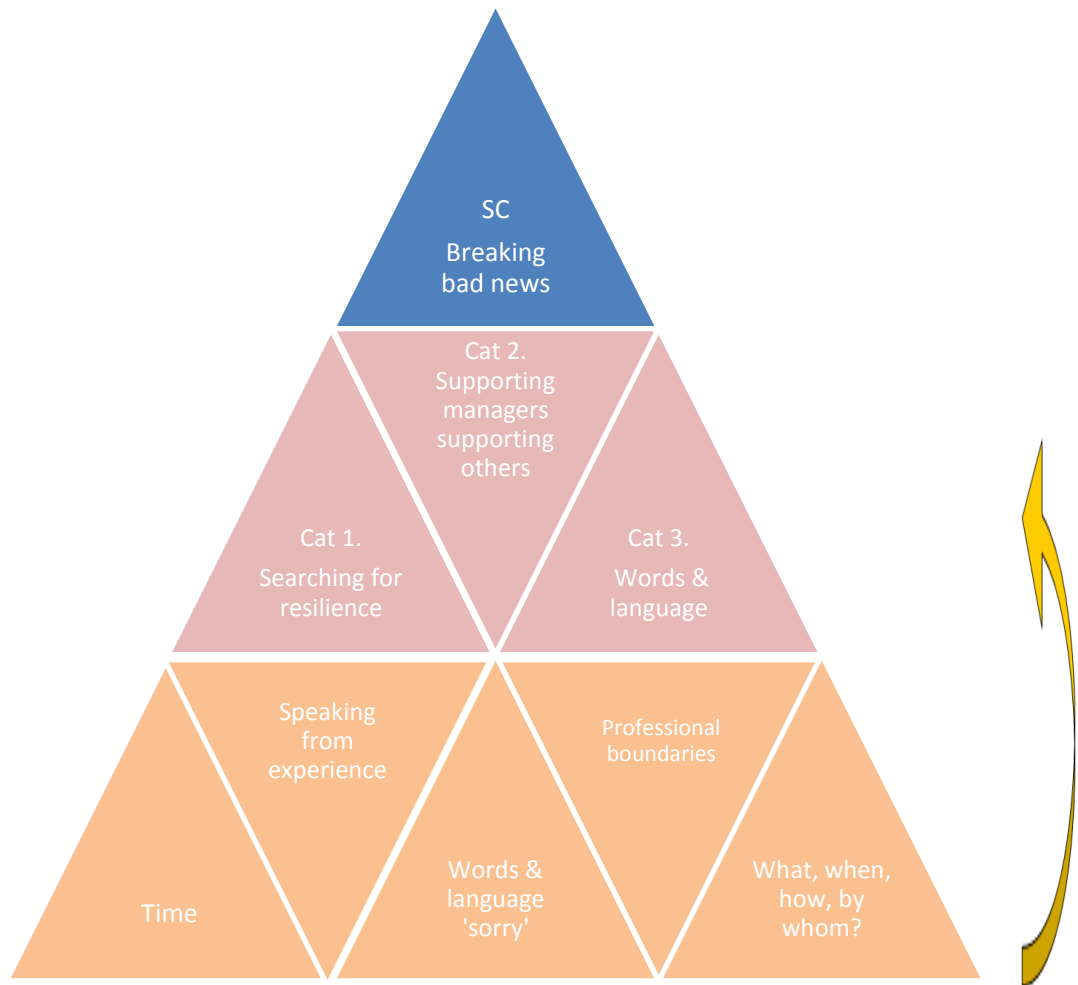
Figure 19 shows the subcategory of 'Breaking bad news' at the top with categories and early codes underneath. It is important to mention here that the analysis was still in the early to middle stages with core categories and subcategories still being compared, contrasted and linked with the literature, field and diary notes.

5.2. The process of analysing all the staff interviews.

This section describes the analysis of data from the staff interviews, after and including the interview with Zoe. As the data grew the analysis continued. Having coded and themed the data into many groups it became necessary to focus on particular elements and organise the data and themes into subcategories. At this point I would like to show the earlier analysis of the development of the 'breaking bad news' subcategory. I will include more excerpts from the transcript to provide details from the interviews that followed Zoë's and invite the reader to refer to the appendices for more information.

During the analysis it occurred to me that words used when talking about the process of having conversations with relatives after the suicide of their family member seemed to identify the desire in the staff member to say something positive, something that might acknowledge the importance of the person who had died. The category of searching for 'resilience' became more affirmed with the context of BBN and is referred to in Figures 19-20.

Figure 20 Subcategory example of: Breaking bad news (SC3), showing axial (orange), focussed (pink) and the subcategory (blue)



Searching for resilience is described later, however another code began to form in the shape of 'consoling others' and 'saying sorry', which through research supervision and reflection developed into category 3: 'words and language' and became 'saying sorry with sincerity'.

Figure 21 shows an example of building upon early codes of analysis from the interview with Zoe and presents an excerpt of the transcript from Yvonne's interview, describing step by step the process of breaking bad news to the mother of a young woman who had been discovered in the hospital grounds after ending her life. I include this long excerpt because it illustrates important information about a number of early codes highlighted grey. Again I include my thoughts within diary notes and memos alongside.

Figure 21 Coding example from transcript of interview with Yvonne (excerpt I)

Line	Transcript of interview with Yvonne (excerpt I)
144	And, ah, one day I, I came to
145	I drove into, I drove into the car park at lunchtime
146	And saw the police there
147	And, um literally the staff had just found her
148	She had cut her throat
149	And uh ...
150	So I spent the whole afternoon, um
151	With the staff and police
152	Talking through and taking their statements
153	And um, at the end of the afternoon
154	I had to go to tell her mother
155	I went with the then unit manager
156	So there were two of us
157	We felt there should be two
158	We felt he knew her better than I did but
159	There was also a sense that being female was important
160	And being the unit manager
161	We didn't phone before
162	We thought about it
163	She lived, um, in a road
164	I still feel shivers every time I go past but, um
165	A country house
166	And we knocked on the door
167	And I think as soon as she saw us
168	she knew, to be honest
169	That something had happened to her daughter
170	And, uh, we had to tell her
171	Um ... as gently as we could
172	And she was shaking and crying
173	Distressed, but I think
174	At one level, not surprised
175	And when we had spoken to her about what happened
176	We talked about, you know,
177	Other family members that she could call
178	To, um, support her
179	So she chose to talk,
180	To phone her other daughter to do it
181	And managed to find a way of telling her daughter
182	To come over without telling her what had happened
183	And we stayed with her
184	For an hour until her daughter arrived
185	We made her cups of tea
186	And, um
187	We probably said all sorts of things
188	And it doesn't really matter what you say
189	Or it's about
190	It's about the way you make that person feel
191	About what a lovely girl her daughter was

Listening to Yvonne, my thoughts consisted of being struck by the impressive way she seemed to consider the multiple needs of those affected, with compassion and sensitivity which takes time, time was scarce but was made ... and still there was someone (staff) who complained that not enough was done for them! Very challenging but borne out in literature.

Yvonne talks about many overlapping areas, themes labelled earlier including 'speaking from experience' and balancing the need for 'professional boundaries'. The need to support staff who found the deceased appeared to be a clear issue, followed by how the decision was reached about who should make contact with the mother, with Yvonne saying that being female was important and that there should be two staff visiting rather than one. Yvonne spoke eloquently about what happened, what she and her colleague did, the time it took and how this left her feeling. This excerpt seems sensitive and compassionate. It was clear that an attempt was made to help the mother cope with what had happened. For example, when Yvonne said, at line 190-191;

"It's about the way you make that person feel about what a lovely girl her daughter was".

Yvonne was trying to focus on something positive in the face of a truly tragic experience. A number of codes were apparent in this excerpt which built on earlier data from Zoe and added to development of category 1 within SC 3: 'Breaking bad news'.

5.2.1 Description of coding from Step 3-4 of Sub Category 3 BBN.

Category 1. Searching for resilience.

Next I will illustrate how I built on the analysis to weave in more data and refine the data I already had towards the category of 'searching for resilience', apparent in Zoe and Yvonne's interviews. Will expressed similar views and I have selected key pieces of text to illustrate this. See appendix for full excerpt.

Figure 22 Amalgam of memos, field and diary notes

In my diary I recorded reflections about the early codes from Zoe and posed questions of the data about professionalism & ethics relating to 'do no harm'

These themes are becoming more prominent, now echoed in other transcripts from Yvonne and Will.

Professional responsibility for practice, however what about responsibility related to someone's choice of suicide? Revisiting the literature tells me ...

Echoing what Yvonne said in lines 424-425, Will spoke of a desire to do no harm when breaking bad news:

“You try and not make it worse ... Try not to do harm”

In addition, Will said:

“See if there’s an opportunity to do something in a small way that could be cathartic or therapeutic for the individual.”

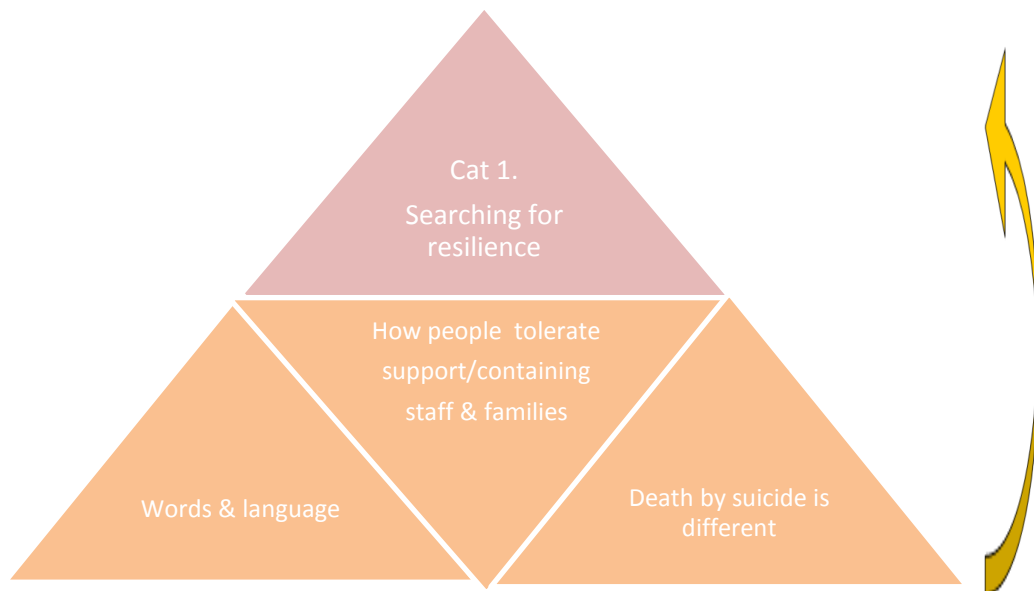
Yvonne made a similar statement at lines 427-430. Will laughed after speaking about;

“Having another awful conversation about something”.

Clearly he did not think that suicide was a laughing matter, through interviewing and transcribing (Oliver et al, 2005) I was better able to appreciate that he felt uncomfortable and nervous. I recall being anxious and nervous myself as he was a very senior manager in the organisation. Will added later in his interview:

“All you can do is try to learn from it ... Be more sensitive and aware for the future.”

Figure 23 Construction of category 1: Searching for resilience, showing movement from axial to focussed codes and themes.



As in the previous data ‘Searching for resilience’ was a theme not only for families and relatives of those who had completed suicide but also staff members, echoed by Yvonne in lines 1010-14;

“You know your staff, their resilience, and their strengths ... some staff read a lot, some staff take a lot.”

In another of the staff interviews, Vic added the following (lines 1052-63):

“We are amazingly sensitive, reflective, and thoughtful, and when it comes down to it, we can’t do anymore”

Which was further supported by Will (lines 155-58):

“[we need] mental health skills to get people to get through a really difficult situation.”

Diary note – Having tracked development it seems relevant to include the theme of ‘consoling others’, into the category of ‘searching for resilience’

It is hoped that the blended excerpts above provide a sense of the process of comparing and contrasting the six interviews, which then formed the codes of ‘searching for positives’ and ‘resilience’. This appeared to be combined with a desire to try to provide some containment by being alongside the bereaved family member.

To summarise where I am up to, having presented examples of the analysis of staff interviews; from grey open codes through to the various levels of subcategories and core categories, I would invite you to see the appendices for details of the analysis that followed. This takes me to another level of analysis: considering all of the staff interview data and codes.

5.2.2 Categories across staff interviews as a whole.

The analysis so far illustrates how raw interview data combined with diary, field notes and memos evolved. I tracked the analysis of Zoë’s interview using grounded theory. Only after the all of the interviews were transcribed and analysed using the same method, did the categories take clear form. Charmaz warns:

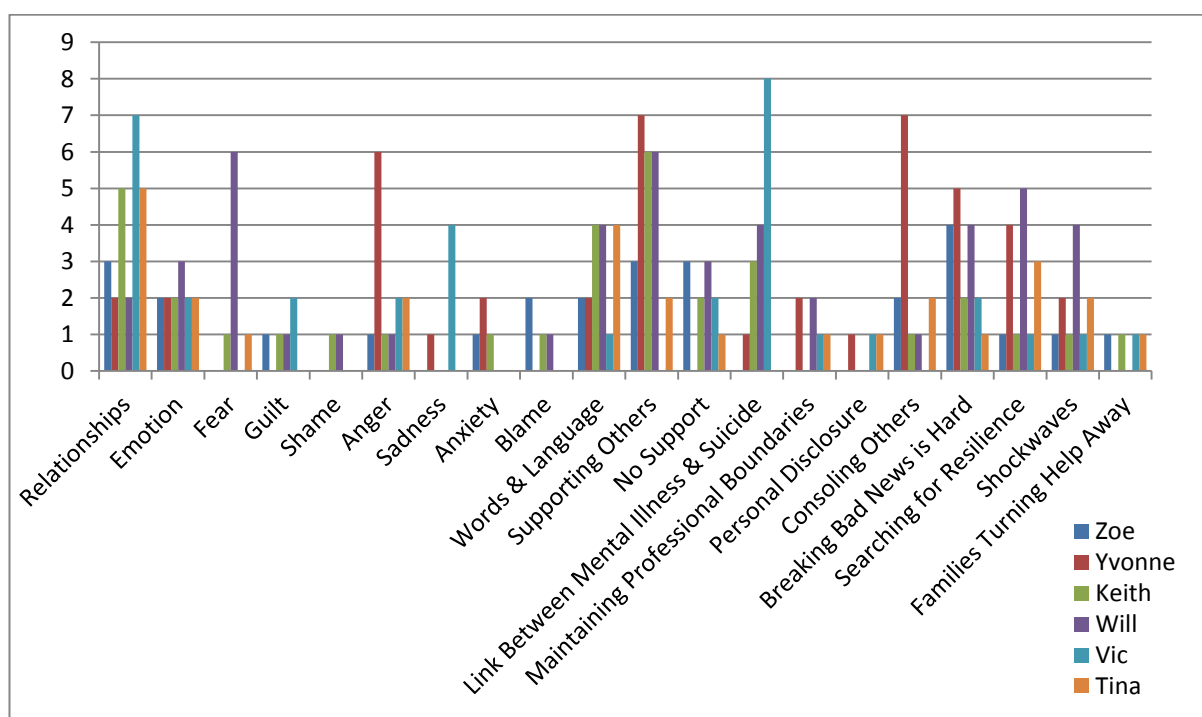
“Categories are saturated when gathering fresh data no longer sparks new theoretical insights, nor reveals new properties of these core theoretical categories” (2006, p. 113)

Having interviewed the staff members it seemed that no new material was being articulated therefore saturation point was reached. This marks a critical point in

the research process and indeed I felt a sense of satisfaction in the anticipation that the data would be sufficient for the purposes designed. That said I was also aware of the need to remain open to new ideas and concepts.

Before reaching the point of presenting the core categories I would like to include a description of how I moved from the first interview and the codes that followed thereafter to the staff interviews as a whole. The format of this thesis does not permit for all data and information to be presented, again echoing the challenges of translating a dynamic fluid process into a linear account. It has been a struggle to decide on what to include and what to omit, however an important part of this research has been reaching various levels of analysis which inform the development of the work. To show where I was up to see Figure 24, which sets out the codes across the whole of the staff member data set.

Figure 24 Analysis of the codes across all staff members graph.



The above data is presented to show how the process of early coding led to subcategories and then core categories.

Throughout the process of data collection and I was keen to gather comments from other 'like minded' clinicians, colleagues and supervisors, as this would provide external audit to enrich the whole research endeavour. I was already aware that the broaching the subject of suicide evoked anxiety and high emotions, which had been clearly evident prior to embarking upon participant

recruitment and data collection through my experiences of the board of ethics and consultation with lay people, carers and family members of a person experiencing mental illness.

As many opportunities as possible were taken to exchange ideas and reflect upon the process, which included regular research supervision groups with research course supervisory staff, which continued for the entirety of the course. This consisted of formal presentation of the evolving research in appropriate meetings with senior managers and staff in the host organisation, for example research reviews and seminars, serious untoward investigation reviews, policy development and strategic meetings. Within the research arena, excerpts of data which I had collected through the face to face interviews and transcribed was presented to my colleagues, students and course supervisors at research and data analysis seminars.

For example, when undertaking initial coding of the first Bond family interview, of Mrs Bond and her middle daughter, I presented an excerpt of transcript to research student colleagues and supervisors which afforded the chance to gather reflections and guidance from my fellow research colleagues and proved extremely useful in the process of coding and comparing within the analysis. Whilst some of what they offered as reflections compared similarly to my initial analysis, other insights provided new ways to scrutinise the data. This included a different and perhaps deeper appreciation of the way the family members felt about how they had been viewed by the staff, and how their sense of priorities of care for their husband/father had been heard/responded to.

This resulted in an additional layer of richness and a shift in direction to attempt to take account of the familiarity with the subject that I, within my multiple positions, was constantly trying to grapple with. In another example I invited thoughts and views about themes from the data as they were emerging. For instance when undertaking the initial coding of the interview from Yvonne, my diary and memo records included reflections about the motivations of the staff to enter into the profession and therefore the potential impact for post traumatic stress disorder in the staff themselves if involved with the suicide of a patient, either from the incident itself or the formal processes that ensued afterwards.

This was something that I discussed with clinical colleagues informally during the course of everyday life working in the NHS. In this way ideas and insights

emanating from the research were exchanged and debated, which included reflections about what the organisation does, or does not offer to staff after a suicide happens. Whilst some staff members appeared relatively robust and resilient, some did not.

Indeed through attending supervision groups regularly over the research course and being part of a discussion that consisted of a course supervisors expressions and reflections upon a family relative of their own, having chosen euthanasia, and dutifully visiting family members to say a final goodbye was a privilege that I will not forget. Consequently weaving in these conversations served to further my thinking and the analysis, akin to Sools, (2012) when she describes 'big and small stories'. Such conversations created the opportunity to render and refine my thinking in ways that added another layer of richness. Indeed in this case, clinical staff that had been in similar circumstances after a patient had died through suicide were enthusiastic to offer up their reflections in the knowledge that this would in some way influence the research endeavour.

Essentially staff were eager to debate the very complicated dilemma within the mental health services whereby there is great emphasis placed upon teams and professionals to 'move people through services' which quite often means they will be discharged quickly, resulting in little available time to establish meaningful relationships (with individuals and their families) of the quality which might make a difference if someone is planning or thinking about suicide.

The 'push and pull' of the organisation experienced by staff presents distinct parallels to being in a 'double bind', (Bateson, et al, 1956), which considers relationships of power whereby any comment or remonstrance by those with less power may become silenced. Again this provided opportunity to discuss feelings, experiences and how formal policies, which had to be complied with, may be seen to get in the way of care or be constraining to some, yet convenient 'buffers' to others. Thus the analysis was an iterative process with the themes and categories being tested and talked about with others as a matter of course.

Figure 25 Core categories from the staff interviews

CC1	CC2	CC3	CC4	CC5	CC6
Training needs to...	Emotion	Breaking bad news	Including families All working together	Supporting managers supporting others	Formal processes

The core categories from the staff member interviews provide a format with which to attempt to answer the research question.

5.2.3 Negative Case

Negative case analysis is discussed here, as it is central to the approach of grounded theory qualitative research and informed analysis and rendering along the way. Willig (2008) suggests that to ensure the development of emerging categories unused data must be scrutinised. Charmaz also comments:

“Qualitative researchers often use negative cases as opportunity to find variables or to provide alternative explanations from their developing theory” (2006, p. 101).

An example of this became apparent in the analysis of part of the interview with Vic, who spoke about possible consequences after sudden unexpected death:

Transcript of interview with Vic (excerpt I)

Figure 26 Interview with Vic

Line	Transcript of interview with Vic (excerpt I).	Analysis
V730	“yeah, I was just thinking that	Blending data codes and reflecting in my diary, then revisiting the literature ... Talking as Vic did about a point of view that seemed quite controversial, combined with diary notes and reflective
V731	the London bombings	
V732	say for example that morning	
V733	woken up and wife says	
V734	I’m having an affair	
V735	and I’m divorcing you	
V736	and I’m gonna take all the kids	
V737	and you’re not gonna get anything	
V738	you think oh gosh	
V739	and there you are	

Diary note- found this very easy to relate to regarding the memories of ill relatives and faithful dogs becoming diminished and tired with life...

Sad to see them go but ends the suffering...

V740	they get blown up in	conversations, linking particularly with the experiences of having met with the carer's participation group members previously, who clearly stated their reluctance to even remotely think, let alone consider the suicide of their relative. Therefore I wondered what they would make of the words from Vic, even though he was referring to sudden death by acts of terrorism and not suicide.
V741	and you think oh	
V742	[laughter]	
V743	stroke ah ha	
V744	stroke of luck	
V745	no one knows what's been said	
V746	only I know what's been said	
V474	but, um, so I guess	
V748	not being you know	
V749	flippant about it	
V750	but it's really easy	
V751	to get caught up in the misery	
V752	and the tragedy	
V753	and the sort of risk focussing	
V754	of what we do	
V755	without you know	
V756	maybe in a slightly pathological way	
757	Int - It's important to see the other flip side	
V758	that's possible isn't it	
V759	although there may be more than one	
V760	opening up a view	
V761	rather than just seeing	
V762	mm, mm some of these families	
V763	are living with people who, you know,	
V764	that are very distressed	
V765	very unproductive	
V766	tyrants (3)	
V767	not all necessarily negative	
V768	and maybe it releases people	
V769	from being carers	
V770	you still feel bad in one way can't you	
V771	but feel release in another	
V772	like I've got a lovely dog	
V773	that gets old and ill	
V774	it's really sad to see them go	
V775	but in the end you know	
V776	you have to do a lot of caring	
V777	and it's really difficult to do that	
V778	and it's sort of a sense of	
V779	well you know	
V780	at least I haven't got to	
V781	keep clearing up the vomit"	

Diary note- This is very controversial however does have significance. Something quite different to compare & contrast the codes to...

Words of difference introduced by Vic and Tina voiced an alternative to family members unquestionable caring for relatives who were challenging to say the least.

Is reflected in some of the literature?

Death releases carers

Although unexpected this provided the opportunity to add depth to the data and led also to reflections of having worked with some very challenging people myself. In lines 345-8, Tina added more contextual data:

*"The 'cared for' can be real tyrants
For want of a better word
At home and dictate
And be horrendous."*

Words used here to describe the person being cared for by families as a 'real 'tyrant' certainly presented difference..

This contrasted with Vic's words (lines 721-727):

*"It's easy to assume
That these things are such
Terrible tragedies
They might be, you know
Overtly
Or otherwise
Quite a positive
By product
In the short term or longer term."*

Questions posed
of the data-

*"Death being a
positive by
product.?"*

*"Death releasing
carers?..."*

This then led to the development of codes around the theme of:

'Death releases carers'.

This offered up a way of continuing to compare and contrast the themes and subcategories through the analysis. Whilst not forming a subcategory in its own right, this became a category which overlapped and informed development of other data.

5.3 Family members narrative introductions

In this section the analysis of interviews with family members is presented. I will begin by providing a narrative introduction to each family in order to set the context. Two families were interviewed, as described in Chapter 4, Figures 5 and 6. The first is the Bond family, who lost Brian, a husband, father and brother. Meeting with the Bond family provided two interviews from four different family members. The first was with Brian's widow, Brenda and their eldest daughter, Dawn. The second interview was with Brian's brother, Bill and Brian's second daughter, Jane.

I have consciously resisted the temptation to present the family narrative as a psychological autopsy. Instead I am offering a synopsis of what the families talked about during the interview process. Therefore this is very much my impression. Information is presented to the reader to provide a sense of the family within which the suicide took place. As the interviews took place as part of a research project and not within a clinical service, some information which would usually form part of a clinical assessment is missing. The names of the family members have been changed to protect confidentiality and anonymity in keeping with research protocol and ethics.

Brian's story

Brian Bond was a man in his mid-sixties. He was a son, brother, husband, father and grandfather. Brian was one of a number of siblings and was described by his family as being very close to his mother, brothers and sisters, however he was said to be poor at confiding and preferred to keep things to himself, to “keep his cards close to his chest”. He was a sociable, likeable man who would do anything for anyone and could often be heard laughing heartily. Brian had a dog who he walked twice a day. When his first grandchild was born he idolised him, would put him in the pushchair and go out walking with the baby and dog. Despite leaving school without any formal qualifications, Brian was described as quick-witted and always “one step ahead”. He was a man who read and watched things to form his own opinions, a real “labour man”, but sadly, according to his family, ended up hating them.

Brian's mother had been ill with cancer. His sister cared for their mother until her death, only to be diagnosed with cancer herself. She died a matter of months after her mother. Brian was said by his family to have taken this very hard indeed. His brother Bill remarked that he had not had any real problems before, but the death of his mother and sister, whom he referred to as “like peas in a pod,” seemed to change him. These bereavements happened about 10 years before Brian ended his life, when he seemed to not be a happy person and referred to the “black dog of depression”.

Brian drank alcohol on and off for years, however it had not been too much of a problem until the last 10 years of his life. His alcohol consumption seemed to increase in this time. His family thought this was a symptom of something else. They also noticed that he was spending a lot of money on things he did not need. He would seem to be on a high but then come down “with a bang”. Brian's tendency to dwell on things, which his the family felt led to his downfall. The family tried to seek advice about what they could do to get help and manage Brian's spending, however they felt nothing was forthcoming. He was not the type of person to talk about his problems or go to the GP. By nature, Brian did not like to admit he was unwell. He saw this as a weakness. One of Brian's daughters, Dawn, worked in the local mental health services at the time and tried to access information and help.

Brian went missing one day. He was found to have attempted to end his life by stabbing himself in the neck and slashing his wrists. When Brian reflected on this afterwards his grandchildren came to his mind, which stopped him doing anything more. After he was found and admitted to hospital Brian needed heart surgery, the family felt it was a miracle he survived. Whilst recovering from his injuries the family visited him. Lots of promises were made by staff about what kind of support they would receive. But since that point, even though Brian appeared to physically recover, he was never felt by the family to be the same and regretted not ending his life.

The family felt support did not materialise. When Brian took an overdose and retreated to bed, although his wife sought urgent help, the family were surprised that he was allowed home and not admitted to a psychiatric hospital. Brian was followed up by a Community Psychiatric Nurse (CPN), however the family did not feel included in the care that was being provided for him. Only after Brian's death did they discover he did not consent to the mental health services sharing information with them. The family said what little they knew about the plan of care, which included Brian attending an Alcoholics Anonymous group, was not the right sort. They felt the mental health services did not listen to them, despite trying on many occasions to put across their points of view. Consequently they felt they were fighting 'a losing battle'. They had hoped that the care provided would help to 'build' Brian back up again. But instead, when Brian talked about the AA group, they thought he tended to compare himself favourably to other group members and minimise his own problems. Hence the family felt a sense of inevitability about the future. They added that Brian was safe if the dog was with him. The day he left the dog at home was the day Brian he did not come back. In hindsight the family say they can see now that Brian went around apologising to people for the way he had been, saying 'goodbye' with an air of 'permanence', a couple of weeks before his death. Brian's daughter, Dawn, had hoped that the grandchildren would: "give pleasure and joy, which would be enough," but this proved not to be the case.

The family said the funeral was a massive event, that the church was 'full to the rafters', such was his popularity. However they spoke about a lack of contact

from the mental health services. A year later the family attended the coroner's inquest and expressed the view that it was a complete 'whitewash', 'a farce'.

Brian's brother, Bill, said:

"All I wanted to know was why didn't somebody do something?"

The family felt the inquest did not have the answers they were looking for and that the coroner did not have an answer either, which amounted to;

*"a complete cover up ...
whoever it was down there they should've been held to account
but they weren't."*

The family felt their views were not taken into account and wanted an apology:

"An apology would have been nice ... we want a "we're sorry" from the organisation afterwards".

Since Brian's death his youngest daughter has experienced mental health problems and fortunately the family has had a better experience with the mental health services this time. However for the family the fear for future generations and worry that the legacy of suicide remains.

The next section provides a narrative summary of the second family, the Clarks. One family member was interviewed about her experience of two suicides: those of her son followed shortly afterwards by her mother. The Clark family comprised of Vera, a lady in her eighties who had experienced anxiety and low mood for much of her life, her two children, Chrissie and her brother. Chrissie and her husband had three children, the oldest was married without any children at the time and the youngest was married without any children. Their middle child, Adam, had experienced emotional difficulties in his early twenties which were thought to have begun in early childhood.

Adam's story

Adam was Chrissie's second and middle child. He was described as sensitive, shy, reserved but creative and artistic, somewhat different to his siblings. Adam wasn't keen to mix with his peers. He preferred to stay at home and really did not want to go to school. Nonetheless Chrissie said it was a complete shock when Adam took some tablets and alcohol when playing with a friend at their house, which seemed to be the result of a minor falling out. Adam was aged about nine or ten years old at the time. Chrissie became aware of Adam self-harming when she noticed 'criss-cross' cuts on his arms during his teenage years. However, despite his struggles Adam managed to get GCSEs and A-Levels, had a settled relationship, then went to university. Adam had some sessions of psychotherapy; however these ended when he moved. At the same time Chrissie became aware that Adam was using illicit drugs and drinking a lot of alcohol. When the relationship with his girlfriend broke down, Adam started to experience panic attacks and was not able to keep up with his studies at University. After spending the holidays with his family, Adam did not return to university and it was later discovered that he had accrued significant debt. Having started on antidepressants, Adam was also continuing to drink heavily. Events developed, he took an overdose and seriously self-harmed, then Adam phoned his mother to say "goodbye". Chrissie and his father rushed over to his house and took Adam to the A&E department of the local hospital, after which Adam was kept on "suicide watch" before being seen by a psychiatrist.

A psychiatric inpatient admission of some four months followed, after which Adam appeared to improve. However, according to Chrissie follow-up appointments were lacking, disconnected and Chrissie struggled to be included in the meetings and plan of care. It seemed difficult to understand the criteria by which people could access mental health services, which according to Chrissie meant she felt Adam did not receive the care he so desperately needed. As time passed the situation became worse, then the day came when Adam did not come to see Chrissie, as arranged. She and his father went to visit him at home, only to discover him dead, having ended his life. The events that followed Adam's death are discussed more later. Completely grief stricken, Chrissie went to stay with her eldest child and family, who were expecting their first baby within the couple of weeks following Adam's death. Within two months of Adam's death, Vera, Chrissie's mother also ended her life.

Vera's story

Chrissie described her mother as a woman who had seemed very anxious and impulsive throughout her life. She was a great worrier, never calm and had made many attempts at suicide. This risk was felt always to have been present, however to a large degree was managed through the relationship with Chrissie's father, on whom Vera depended, combined with the intermittent involvement of mental health services. Upon the death of Chrissie's father, Vera's requests for emotional and practical help increased, so much so that consideration was made about how best to support her in conjunction with mental health services. This included whether that would be left at home alone or moved into supported/sheltered accommodation.

Chrissie felt actively involved in this plan and said she felt very engaged with the mental health services and her mother's GP. However Chrissie also said that she felt that Vera was very unhappy. Vera apparently contacted the services frequently out of hours making requests for more medication, including pain-killers, however there did not appear to be a physical explanation for the pain she was reporting. When Adam died and Vera implored Chrissie to be with her as she felt unable to cope, Chrissie said she did not feel able to go to her mother or "take it on". Instead Chrissie went to be with her family and new born grandchild. When Vera phoned and realised Chrissie was with them she ended her life shortly afterwards. Chrissie said she struggled with the thought that this might have been the cause. She referred to the concept of a "domino effect of suicide". Chrissie wondered if one suicide in a family might grant permission for others to kill themselves;

"It's almost permission has been given for you to go."

The experience Chrissie described after Vera ended her life was different than after the death of Adam. Chrissie spoke of having the sense that her mother had given up and did not want to continue living, as figure 27 shows:

Figure 27 Coding example in the transcript of interview with Chrissie (excerpt I)

Line	Transcript of interview with Chrissie (excerpt I)	
83	survived a considerable length of time really	Diary notes mark the link between what Chrissie said here with comments from Vic's interview ...
84	and, um, really didn't have any wish	
85	to go on living	
86	cos after my father died	
87	she'd given up	
88	so, you know, it wasn't ...	
89	I felt it was really what she wanted	

Chrissie spoke very highly of the contact she received from the mental health services working with her mother both during her care and after her death. The staff made prompt contact with her, made time available for her to meet to discuss what had happened, which seemed in accordance with best practice. However, Chrissie's experiences of suicide were very different, even though they happened after the 'Being Open policy', (NPSA, 2005). This will be explored further later.

5.3.1 The process of analysing family interviews

In keeping with the approach used with previous interviews, based on grounded theory, open codes were grouped around and linked with each other into themes and categories, then the analysis took shape and moved towards subcategories. As with the staff interviews, I include excerpts of transcripts and figures to explain the process. It is important to mention that as the family interviews consisted of more than one participant when being transcribed, each family member was given a separate identifier to provide clarity about who said what, when, etc.

Taking subcategory 1: 'Family not being heard', members from both families held the view that they did not feel listened to or heard by the mental health services. The analysis of subcategory 'Family not being heard' is presented below with excerpts of the interview transcripts with Jane (Figure 28) and Chrissie (Figure 29).

Figure 28 Example of transcript Bond family interview 2 (Excerpt I)

LINE	Transcript Bond family interview 2. (Excerpt I)
B(2)151	[we were told] if your dad comes out of this
B(2)152	They'll be opportunities, treatments
B(2)153	I remember thinking –
B(2)154	that's fantastic
B(2)155	We hadn't even got to the point of knowing
B(2)156	whether he's living or not and they are offering [lots]

This experience left them feeling optimistic initially, but their hopes for further support were dashed, as Jane added in lines 160-161:

“But it never happened ... It never happened.”

This was blended with words from Dawn, Brian's eldest daughter, in lines 495-502:

*“since the first time he tried to kill himself ...
he didn't want to be alive
... he regretted it wasn't successful.”*

The disappointment voiced by the Bond family resonated loud and clear...

The family's bitter disappointment reflected how they felt about the 'empty promises' made to them alongside the challenges of being asked to provide care that was unfamiliar to them, and meant significant changes in the way the family relationships worked. The expectation of the mental health services for them to take on the care of their relative, whilst not overtly stated or requested, was assumed, irrespective of whether or not they were able or indeed willing to do so. And no support was offered to them as carers.

*B(2)1141 “from the very start
B(2)1142 when dad first tried to kill himself
B(2)1143 just a lack of family support”*

The code of 'lack of involvement' continues in an excerpt from Chrissie's interview:

Figure 29 Example of transcript of interview Chrissie Clarke (Excerpt II)

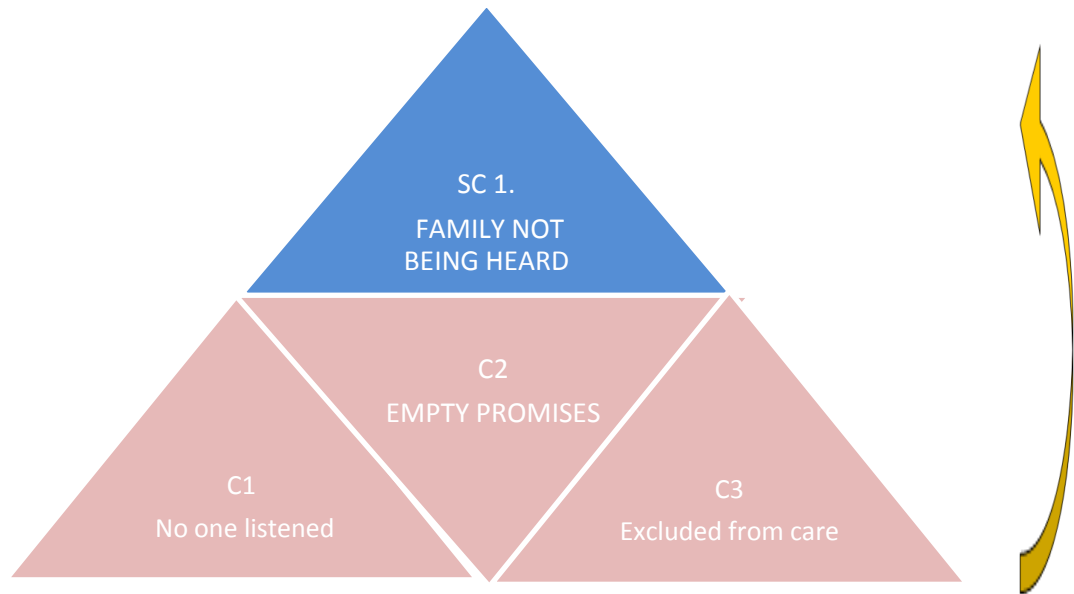
Line	Transcript of interview Chrissie Clarke (Excerpt II)
01	Carers are so often overlooked
02	and they are such source
03	a huge bank of information
04	...
05	It's getting better I think in [locality]
06	but at the time of my son's death
07	it was just me that thought , uh
08	information was kind of
09	Blocked
10	and I don't know whether
11	that was because of
12	rules of confidentiality or whatever
13	It's because the practitioners weren't, um
14	weren't speaking to each other
15	and kind of realised
16	Realised perhaps they should have been
17	but there was no protocol for it to happen
18	I don't know
19	It's hard to know when you're on the outside
20	Um, you know
21	you sort of feel like um
22	Um
23	a huge sense of frustration
24	because you know your individual
25	you know your child
26	you know your adult
27	and you knew what was happening
28	and yet you couldn't seem to
29	marry up, you know
30	all of the service
31	and co-ordinate anything

Field & diary notes reflect upon the way Chrissie describes the real sense of frustration she experienced when trying to fight for help for her son, which is mirrored in the literature ...

Diary notes here link back to my reflections about the 'braided challah' when you have something precious you do all you can to preserve it, weave together, coordinate things as any mother would ...

Here Chrissie speaks of the frustration she felt trying to let mental health services know about the risks to her son, Adam. Issues around 'confidentiality' and channels of communication, or the lack of them, were echoed by both families. Confidentiality was something referred to by both families and certainly became a feature when posing questions about the data during the analysis process. This was coupled with a loss of confidence in mental health services as shown below.

Figure 30 Sub Category 1: Family not being heard

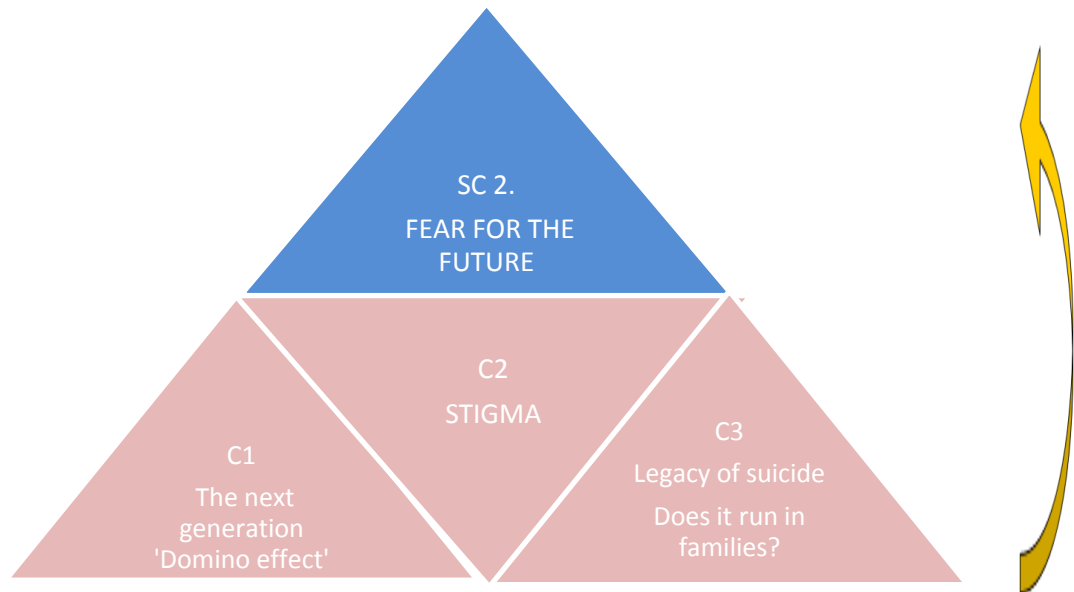


This moved the analysis and meaning-making to another level when considering the family members in the future, which links to the next subcategory of 'Fear for the future ...'

5.3.2 Description of coding. Subcategory 2: 'Fear for the future'

This research focusses on the family member's experiences with mental health services after the suicide of a relative; however it is also important to consider that in most families family life entails looking to the next generations: children, grandchildren, nieces, nephews etc. Having lost a husband, brother, father and grandfather, the Bond family stated great concerns for other family members who were also experiencing problems. Likewise Chrissie made comparisons within her family to similarities in temperament that might be genetically determined and mean a heightened susceptibility to mental health problems or suicide. This may indeed relate to their motivation for taking part in this research; however what became clear was that the family members I interviewed raised really important issues on behalf of future generations and families in general.

Figure 31 Subcategory 2: 'Fear for the future'



All of the family members spoke not only about their concerns for future generations within but also the wider community. The following two excerpts are included to show open codes in grey, as expressed by the families.

Figure 32 Example of transcript of Brenda & Dawn (Bond family int1) (Excerpt I)

Line	Transcript of Brenda & Dawn (Bond family int 1) (Excerpt I)
924D	Hoping lessons have been learned
925D	Other family member
926D	was that, um
927D	my sister ... she tried to kill herself
928B	yeah, yeah
929D	um, um, last October didn't she? [to B]
930D	it was kind of serious but not
931B	it was half hearted
932D	she kind of went off
933D	um, went off into a um
934B	the lake
935D	like a lake, just waded in
936D	with the intention to
937D	sort of drown herself
938D	and so she um
939D	Ended
940D	she, she didn't
941D	she wasn't admitted was she?

Figure 33 Example of transcript from interview with Chrissie (Excerpt II)

Line	Transcript from interview with Chrissie (Excerpt II)
45	my mother had, you know, made
46	so I do think that
47	quite possibly, um
48	decided party genetically
49	Um, my mum suffered all her life
50	from anxiety and um
51	subsequent depression
52	and um, you know I can remember
53	Looking back
54	retrospectively now I can see
55	how similar mums problems were
56	to my son
57	Um, sort of impulse behaviour
58	Um, just not being able to be calm really
59	it was like
60	they never really had a diagnosis
61	apart from anxiety and depression
62	but there was some kind of impulsiveness
63	that meant
64	they would be calm one minute
65	and then they be off the scale another
66	and it, I think there was a suggestion
67	Um, about
68	a misregulation of emotions
69	could be part of what was happening
70	and that describes it exactly
71	sort of almost
72	mute passivity sometimes
73	and then becoming, um
74	not manic but close
75	Um, and it's funny how they were just
76	such similar people
77	but of course my mum was older

Diary notes made mention of similarity and difference in family members – susceptibility perhaps to becoming unwell.

Difference introduced by the age of the person that died ... is this more or less acceptable?

Whilst Brenda, Dawn and Chrissie all seemed to be struggling to understand the reasons their family members ended their lives, the subcategory 'fear for the future', the 'domino effect' and 'the legacy of suicide' stood out and linked to the 'stigma' that seemed to be associated with suicide and mental illness.

As Dawn Bond stated (lines 21-32):

"It is actually more about other people's reactions ...

We had a conversation with a friend who hadn't realised my father was dead

...

[I was asked] How did your father die?

Well he actually committed suicide and it's that oh ..."

Dawn was deeply concerned about the impact this suicide might have on others. This led on to thinking about how to protect future generations and a fear of the unknown, summarised by Dawn Bond in lines 1052-69:

"Children in the family and their development ...

they were too young to know how he died ...

*didn't go to funeral ...
fear of them picking up on what people might say ...
children not understanding ...
depression runs in the family."*

Curiosity about the impression held by the families that depression might run in families seemed to also suggest the question:

Does suicide run in families too?

For Chrissie, the fact that her mother was older and had made suicide attempts before seemed to make a difference in terms of lessening the shock (Figure 27). I mention this because it introduces the idea that suicide by an older person is more acceptable than that of a young person.

5.3.3 Description of coding. Subcategory 3: Formal processes

Within the family member interviews each person spoke about how the mental health organisation provided services for their relative, as well as the way they related to them after the death. Again much of the data overlapped with other codes and themes, however a flavour of a developing subcategory was provided when Bill spoke about the coroner's inquest:

Figure 34 Example of transcript of interview Bill & Jane (Bond family 2)

Line	Transcript of interview Bill & Jane (Bond family int 2.) Excerpt I)
1111B	It was a complete whitewash
1112J	Yeah, that was a farce.
1113B	We all turned up to the inquest
1112B	and Dr 'whatever her name is'
1115B	hadn't even sent in a report,
1116B	you know,
1117B	and we'd all traipsed down to [location]
1118B	There was nobody there
1119B	that was actually responsible
1120B	for anything
1121B	you know, they just seemed to
1122B	push it aside
1123B	and they didn't wanna know.

The words above provide a real sense of Bill and his family's feelings when they arrived at the Coroners hearing the psychiatrist had not provided a report, which led to the Inquest being postponed and another date being set. The disbelief and trauma created by this was evident. For Chrissie, being included in the investigation of Adam's death by the mental health service did not happen as she would have liked. Firstly she was not included at all in the investigation. When Chrissie contacted the Trust to ask about the investigation the Trust

eventually sent a report, which concluded that the care Adam received was 'good'. The following transcript shows how Chrissie felt about this.

Figure 35 Example of transcript of interview with Chrissie (Excerpt III)

Line	Transcript of interview with Chrissie (Excerpt III)
1837	well I got that report back
1839	saying care had been good
1840	so I wrote back and I said
1841	well that might be the case
1842	but I don't understand
1843	why there hasn't been any communication with me?
1844	you haven't asked for any input
1845	considering all the events
1846	that led up to Adam 's death
1847	and I think I mentioned the 'being open' policy
1848	and I think I remember
1849	I was really persistent
1850	I think I went to what was then the PCT
1851	the safety person there
1852	and I wrote to her and asked why
1853	they had a comprehensive 'being open' policy
1854	but the Trust looking after Adam
1855	didn't seem to have anything
1856	because, that's right,
1857	because she said
1858	it's not common practice for
1859	carers and families to be involved
1860	in any investigation after somebody died

Chrissie said this was like "a red rag to a bull"

Memo extract-combining analysis of the Bond interviews and now Chrissie's: what has happened to 'Being Open'?

The open and axial codes and themes of 'formal processes' eventually emerged into subcategory 3. To illustrate the labelling of the subcategory, "a complete whitewash" was a direct quote from Bill's interview, which summed up how the Bond family felt about the coroner's court.

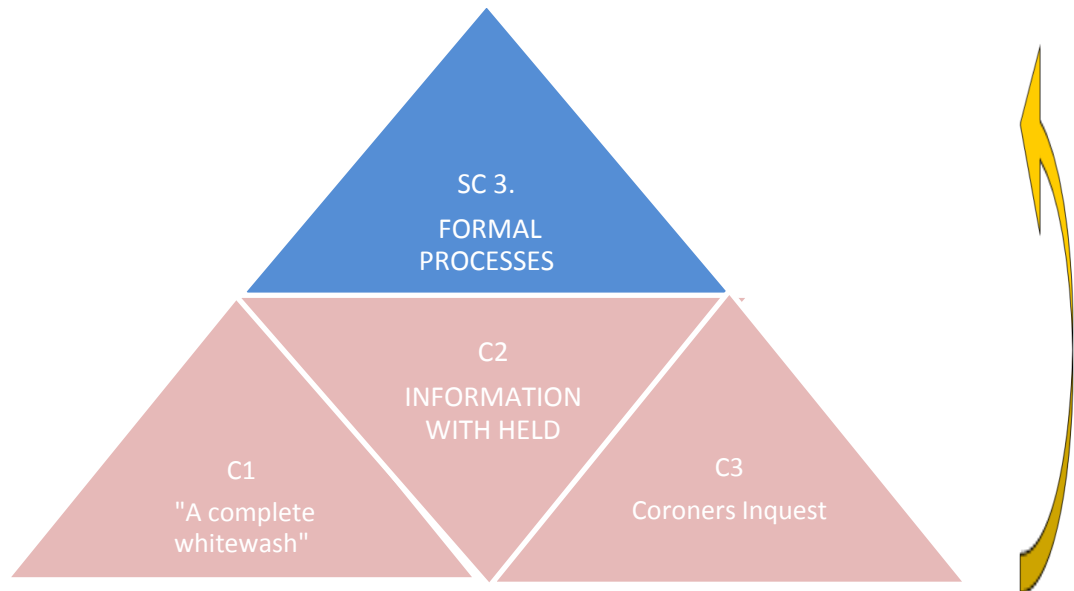
Charmaz recognises the importance of using the subject's own words:

"Insider shorthand terms specific to a particular group that reflect their perspective" (2006, p. 55).

This combined with what Chrissie described as a "crusade" when excluded by the mental health services in the review of Adam's care, and the continued attempts to get "justice" for Adam, meant she battled long and hard in her search for what she and her family felt was near to "the truth". This included a complaint to the Patient Advice and Liaison Services (PALS), to the local Ombudsman and eventually the CQC which culminated in Chrissie being included in the second investigation into the care provided to Adam in the time

leading up to his death. The report that followed revealed gaps in the services, which until then would have been obscured.

Figure 36 Subcategory 3: Formal Processes.



Having described analysis of three subcategories from the family member interviews the others are summarised in the appendices.

5.4 Categories across the family interviews as a whole.

Figure 37 sets out a chart of the early coding and categorisation of data, as consistent with the staff data, which served as a precursor to the development of the core categories.

Figure 37 Family coding chart

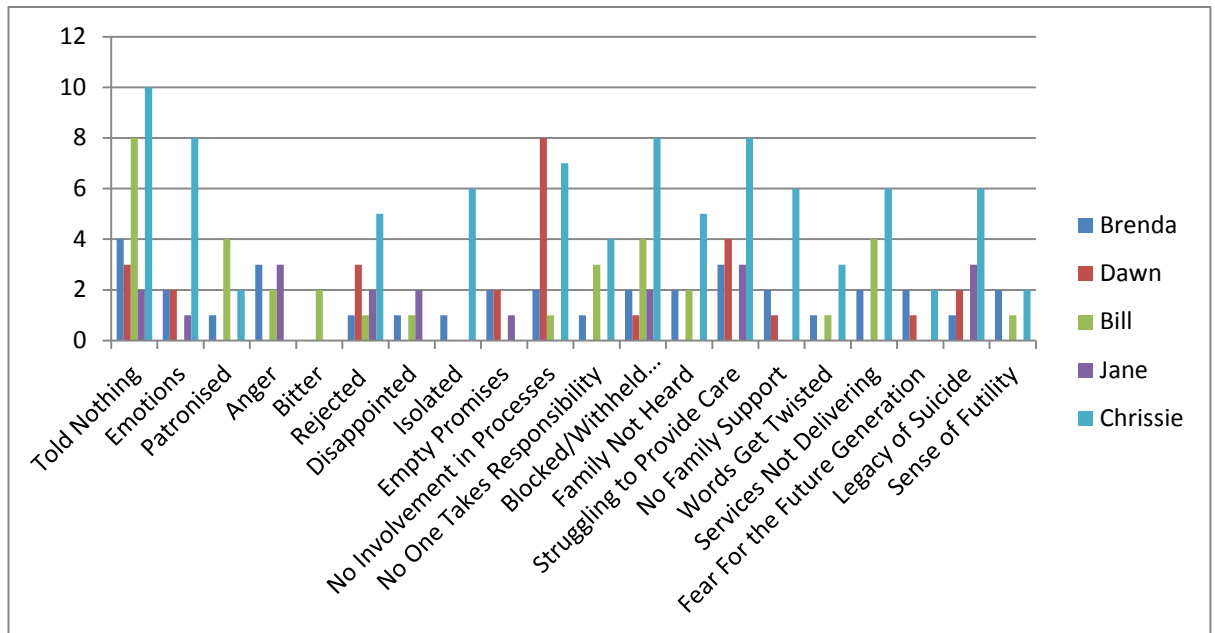


Figure 37 shows the codes and categories that evolved from early analysis and the labels ascribed to encompass their contents, which had been taken from the interview transcripts. Much care and consideration was made of the labelling, often using in vivo codes in an attempt to amplify the voices of family members.

Figure 38 Core categories (family)

CC1	CC2	CC3	CC4	CC5	CC6
Family not being heard.	Fear for the future	Formal processes.	Emotion	Family and service mismatch.	Family motivation to join research.

Figure 38 sets out the core categories that emerged from analysis of the family member interviews. Before presenting a summary of the findings, I will include some reflections about this highly delicate and complex process of analysis.

5.4.1 Reflections during the process of analysis.

An important part of this research has been blending in my reflections and experiences as the researcher. To do this I pondered on an earlier question:

“You think you have an argument. The matter fascinates you; therefore, you presume that anyone would want to read it. But why should your reader care?”

So what?” (Charmaz, 2006, p. 156)

Being by nature private and reserved, revealing myself through writing is no easy feat. However in line with the methodology it was essential to include my personal reflections on the process of analysis and meaning-making. It was difficult to imagine what the reader might need to know about my part in this process, however of note was the relative naïveté with which I approached this endeavour.

During the final months of my Masters research my mother died, which was a monolithic event. During the course of this research many significant things have happened, not least the organisation and sponsor for whom I was working underwent major re-structuring, as did many NHS Trusts. This meant the job I was doing, that underpinned the research project, disappeared, resulting in a number of redeployments and an absence of stability. I remember supervision conversations at the time about my need to be trained and developed by the organisation over several years to carry out a particular role, only to be ‘side-lined’ and seemingly disposed of.

Positioning theory (Campbell & Groenbaek, 2006) assisted me greatly at this time. I was able to consider alternative perspectives on my struggle. Indeed when embarking upon the interviewing for this research, whilst also trying to adapt to the changes being forced upon me, I wondered about giving up. What kept my attention and energy going was reconnecting with the many voices I listened to over the years that talked of being affected in some way by suicide, and I recognise how important this piece of work could be in helping others like them.

One of the most challenging times was when I agreed a date and venue to interview my first family, and I found out that my dear stoic father, whom I had cared for since my mother died, had a terminal illness and a very short life expectancy. Consequently during that interview I was aware of looking into the eyes and hearing the story of people who were mourning a loved one, and that I soon would be in a similar place. My senses were acutely tuned to that family, but inevitably, due to my own concerns, there was probably much I was not able to attend to. The decision to continue was I think courageous but essential in terms of forging a meaningful connection with the family members. They did not and will never know that I sat with them while my father was dying. However

this experience did make me think about the issues of assisted death, the whole debate around euthanasia, physical illness versus mental illness, death through one's own hand and as a consequence of disease.

This reconnected me with emotions I had felt during my previous research project when my mother died. The literature about death and dying was challenging to return to, particularly Weingarten, (2007, p. 16-17):

"I, who has wanted to grow old with my mother, at first wanted her to avail herself of any treatment that might extend her life. Ultimately, in the final hours of her life, I wished her dead. I saw my hope for connection to my mother would forever be in my dreams and my heart and never with the unconscious body lying in the hospital bed. In one excruciating 24 hour period, my hope tumbled through four phases: Please don't let her die became please don't let her suffer, which passed on to Please let her die comfortably, which morphed the most inconceivable hope into a conceivable one: please let her die now".

My mother died almost 10 years ago and I can still feel what a wrench it was. What followed my father's death was a sequence of packing up belongings, selling houses, moving, a general sense of upheaval, which resonated with the process of data sorting and analysis I was going through. At that time a large part of my day to day job involved carrying out investigations into possible suicides. I was thinking about assisted suicide because I was investigating the death of a woman in her 70's who had developed a terminal neurological illness, which resulted in physical deterioration and a loss of dignity. Much of this work involved sitting with and speaking to families or staff, and presenting reports to the organisation about the 'root causes' of the death or suicide.

Within my working life I was subject to much organisational change, as were many others, which taught me much about humility and humanity. During the course of this research I struggled to create time in a setting that requested more and more investigations and less clinical work. Frosh (2013) talks about "necessary hesitancy", a certain way of defensive theorising, whereby concepts are imposed as a grid in a 'top down' fashion and opportunities for open engagement are missed. This question resonated with me:

"How does one maintain the necessary uncertainty, particularly in situations of high pressure in which clinicians or researchers might be required to provide answers?" (p. 16)

Finding distance from the subject matter and appreciating different perspectives was a continual challenge. Referring back to the 'braided challah' (Hoffman, 2000), I felt I was being squeezed by the organisation into a position of only being able to speak in 'absolutes', to take a reductionist view of patient death, where there was little opportunity for curiosity or reflection. This made no sense to me, having worked and studied hard to develop skills that embrace these principles. I found that I was not fitting into the culture of the organisation. My challah-shaped thinking was being forced into a baking tin so only the tips were visible.

I experienced another deployment, after applying for a post I was not appointed to. I found myself feeling uneasy, almost subject to bullying. I fell out of love with the research and all but jettisoned it, however about this time last year applied and was successful in getting a job which provided me with much more clinical contact. Consequently I was able to pick up the research where I left it with renewed enthusiasm.

I mention these facts in order to provide a context to the process of collecting and analysing the data. Earlier I mentioned the positioning compass (Partridge, 2007), Figure 14, as a tool and indeed this approach helped me view through different lenses the difficulties I was having, my position in the organisation and in the context of the research. It was painful but important to appreciate how these experiences affected the research, and made it very difficult for me to continue.

In concluding this section of Chapter 5 I have offered up my reflections on what I was experiencing through the course of the research. I have attempted to acknowledge and take account of the influences that might have impacted upon the process. This leads into the next section summarising the findings.

5.5. Summary of analysis

This chapter provides a summary of the data analysis by:

- Presenting three levels of analysis, including figures
- Refining the core categories
- Constructing a 'conceptual skeleton'

This section presents a series of figures (39-50) that set out the data from three levels of analysis, from orange axial coding into pink selective/focussed codes, then into blue subcategories, which informed the evolving development into the purple core categories. Within the following figures the data comprises early analysis which was brought together, compared and contrasted and within the higher levels of analysis linked to the literature. Through this process all of the figures are presented to show my workings through the three levels of analysis, the precursor to settling on the core categories.

Figure 39 Training needs to..

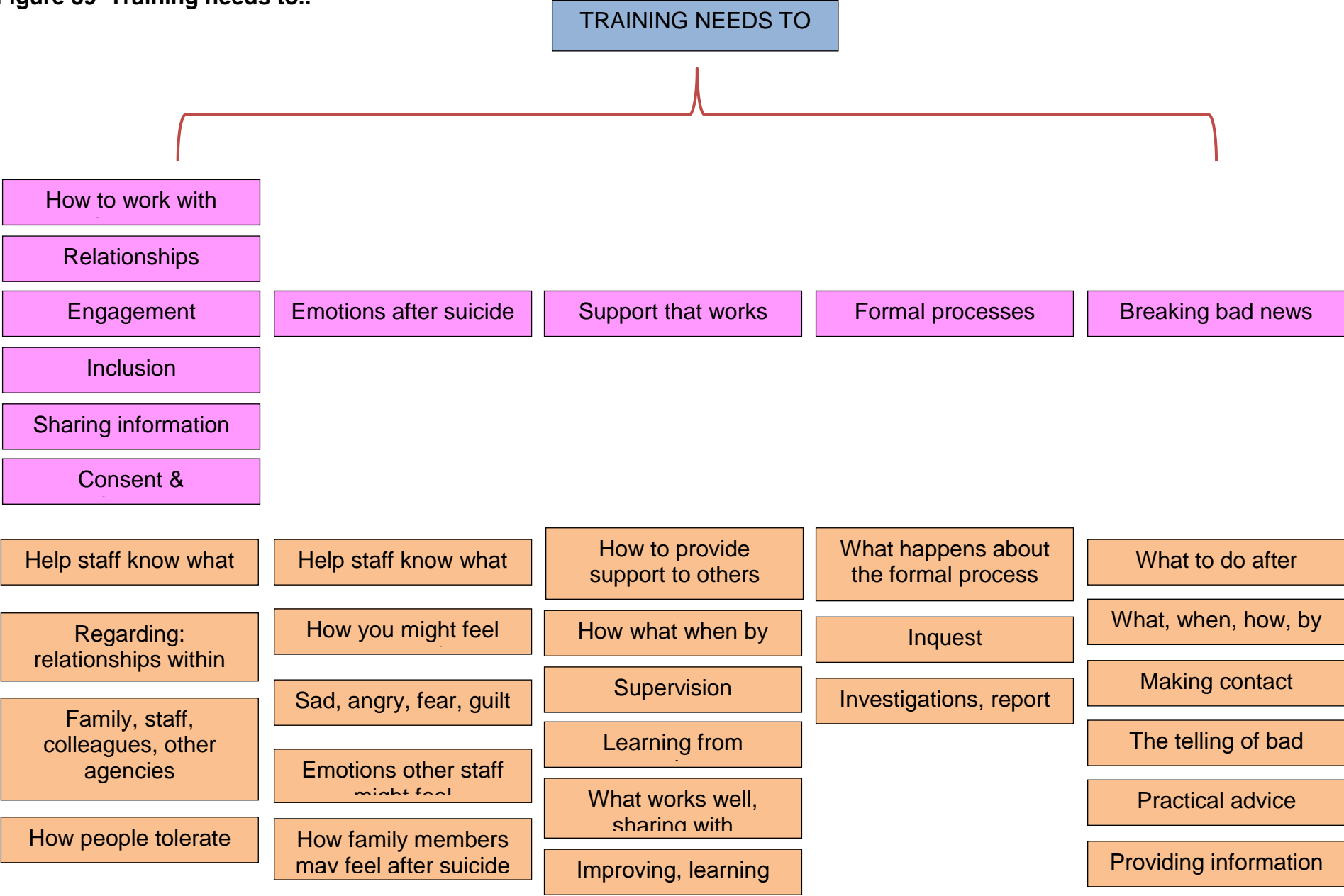


Figure 40 Emotion relating to suicide

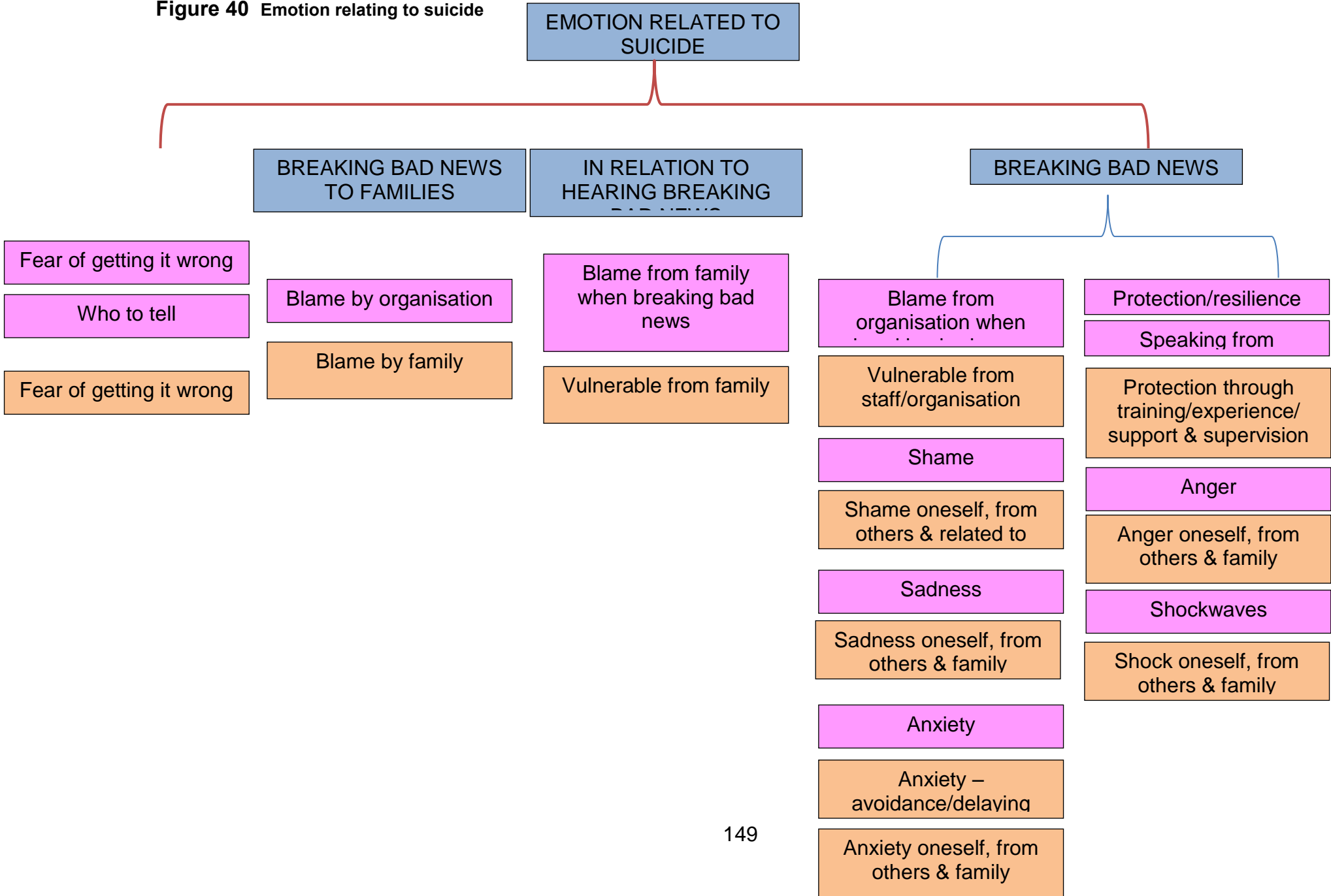


Figure 41 Breaking bad news

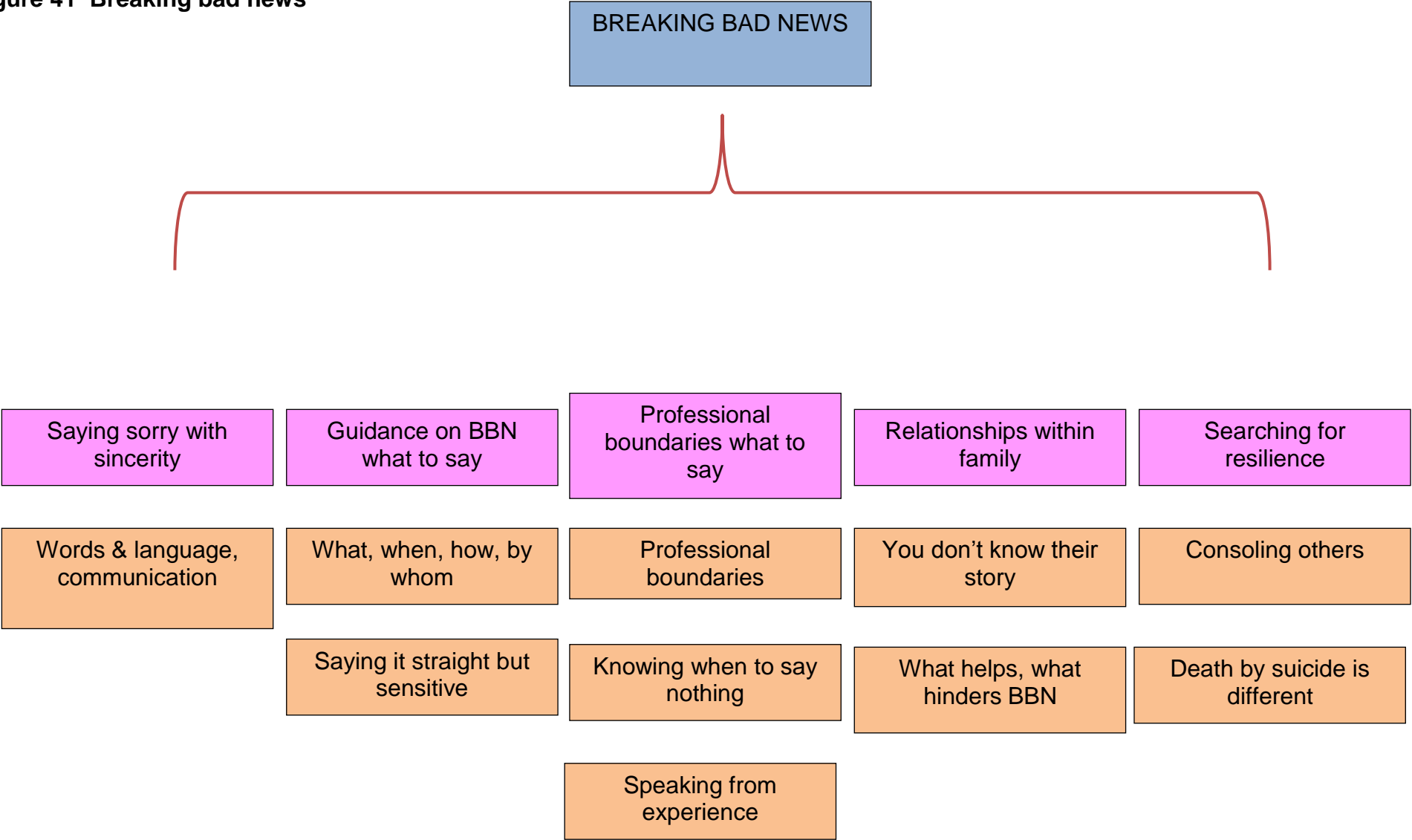


Figure 42 Including families working together

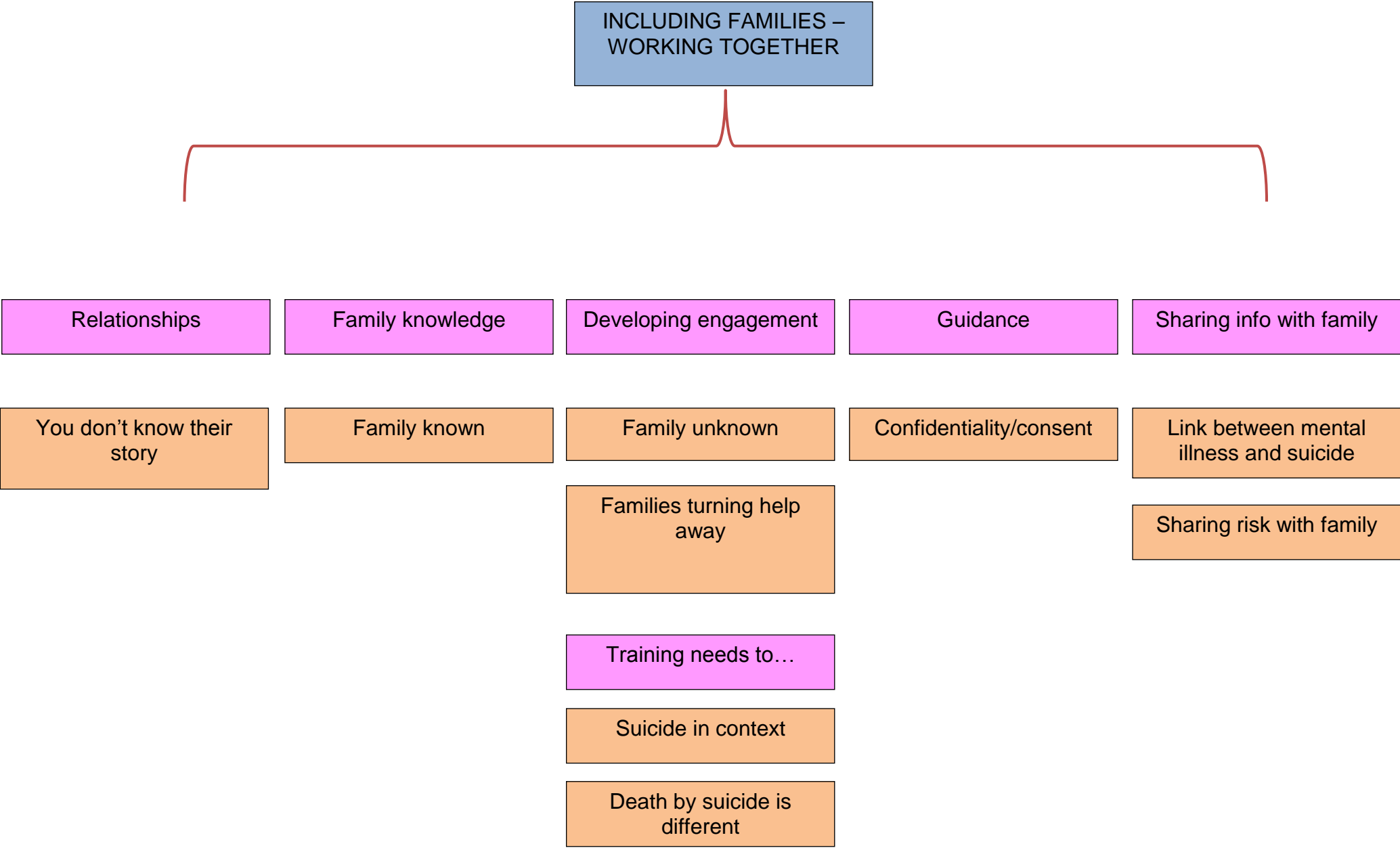


Figure 43 Supporting managers supporting others

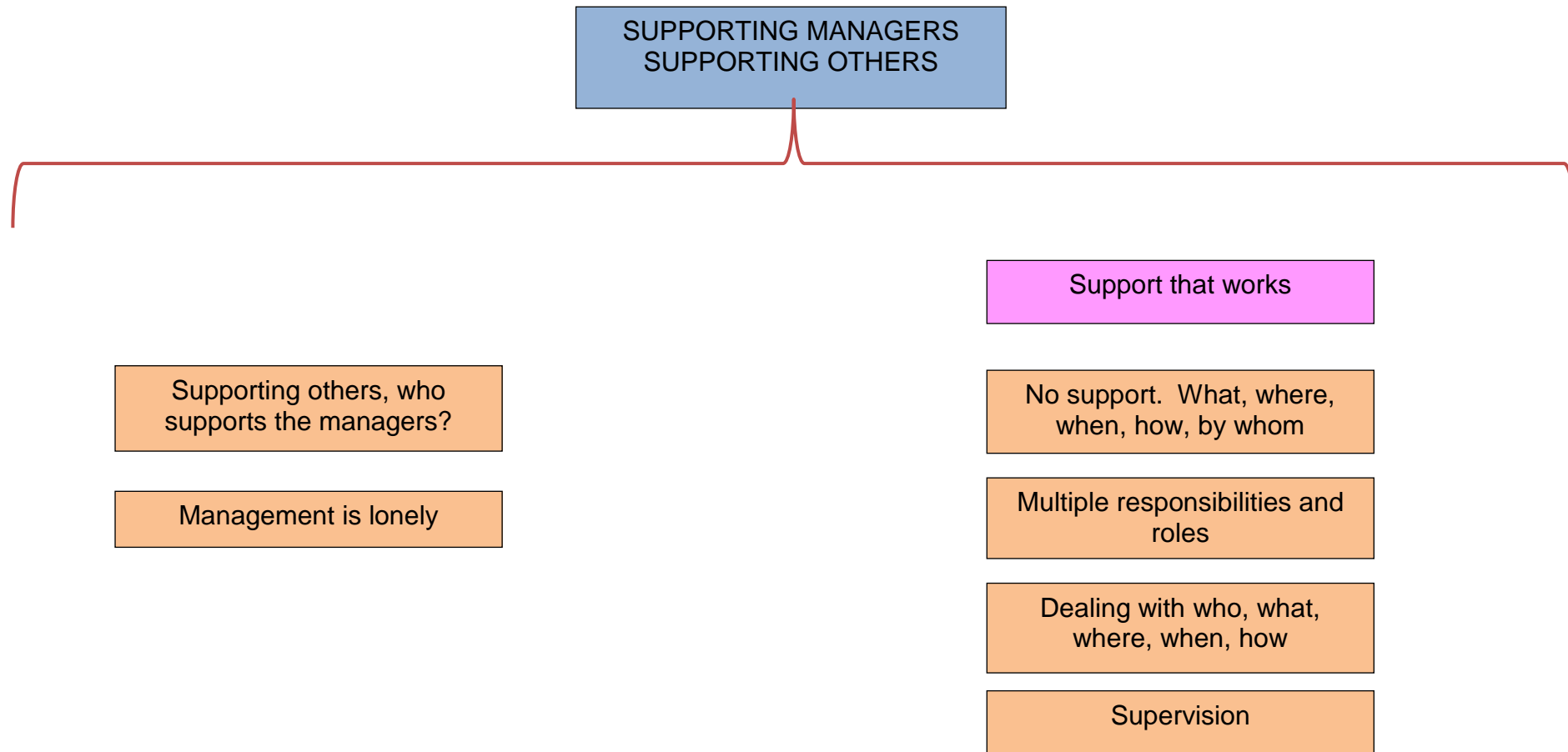


Figure 44 Formal processes

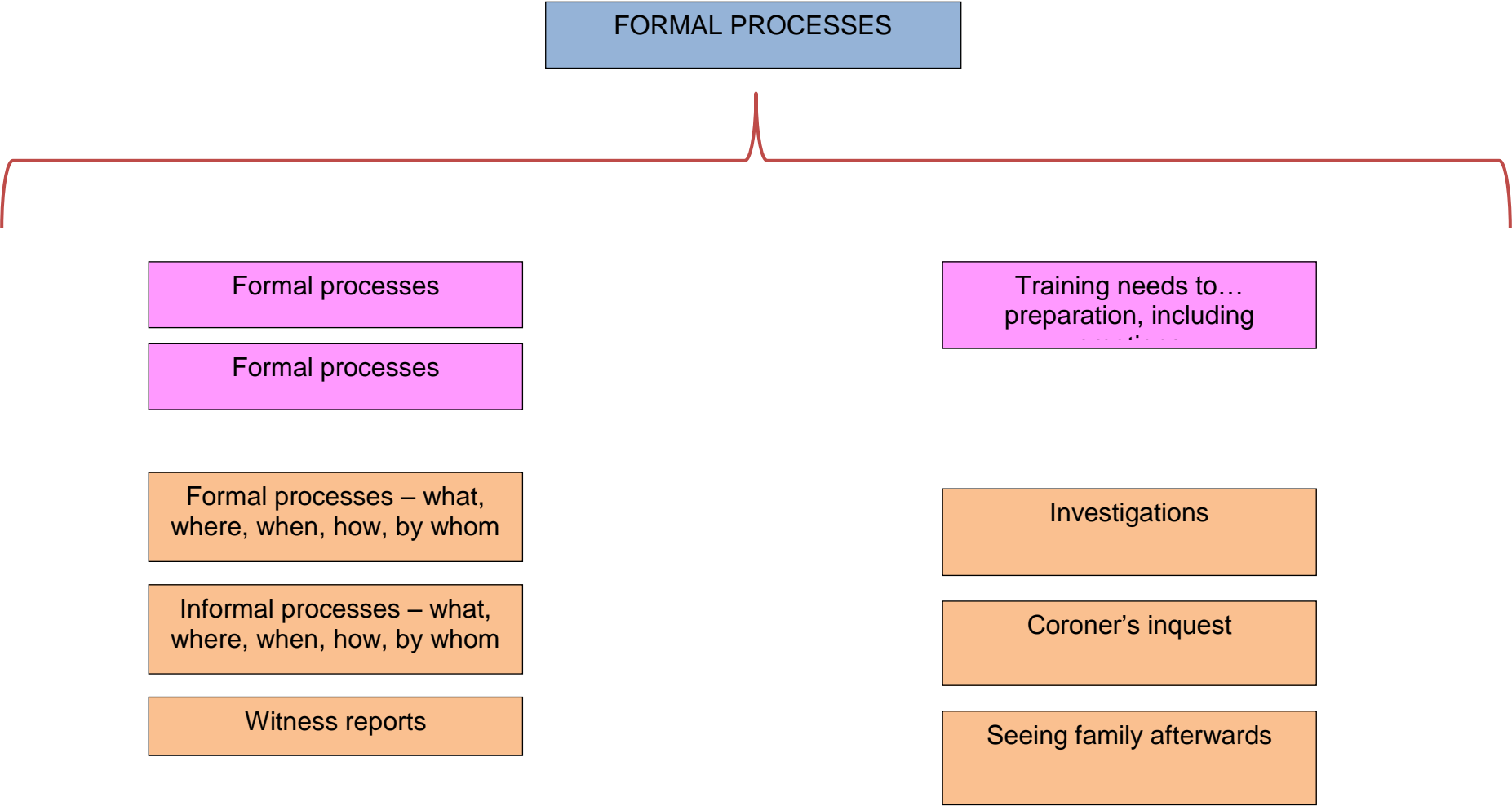


Figure 45 Family not being heard

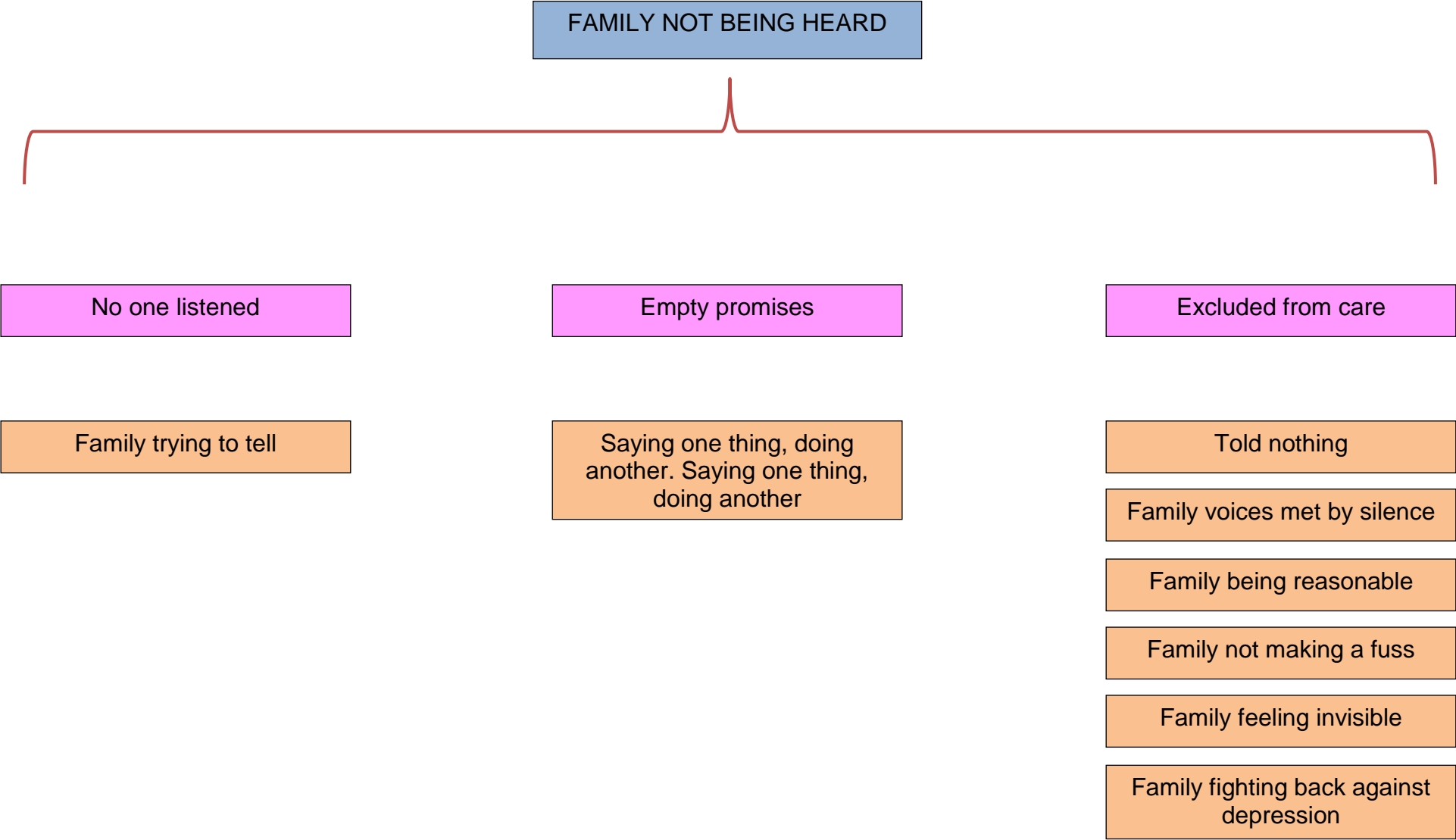


Figure 46 Fear for the future

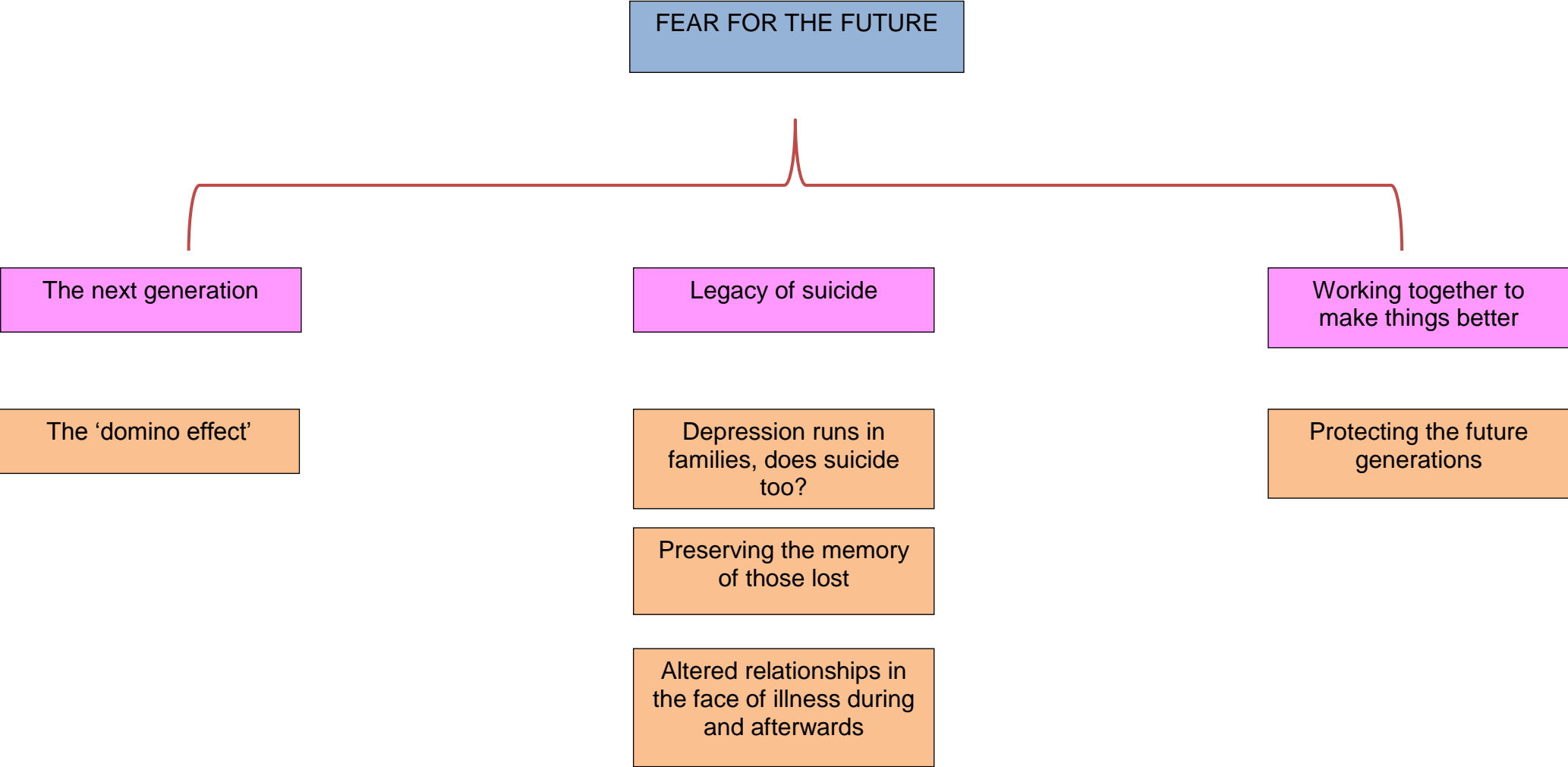


Figure 47 Formal processes (family)

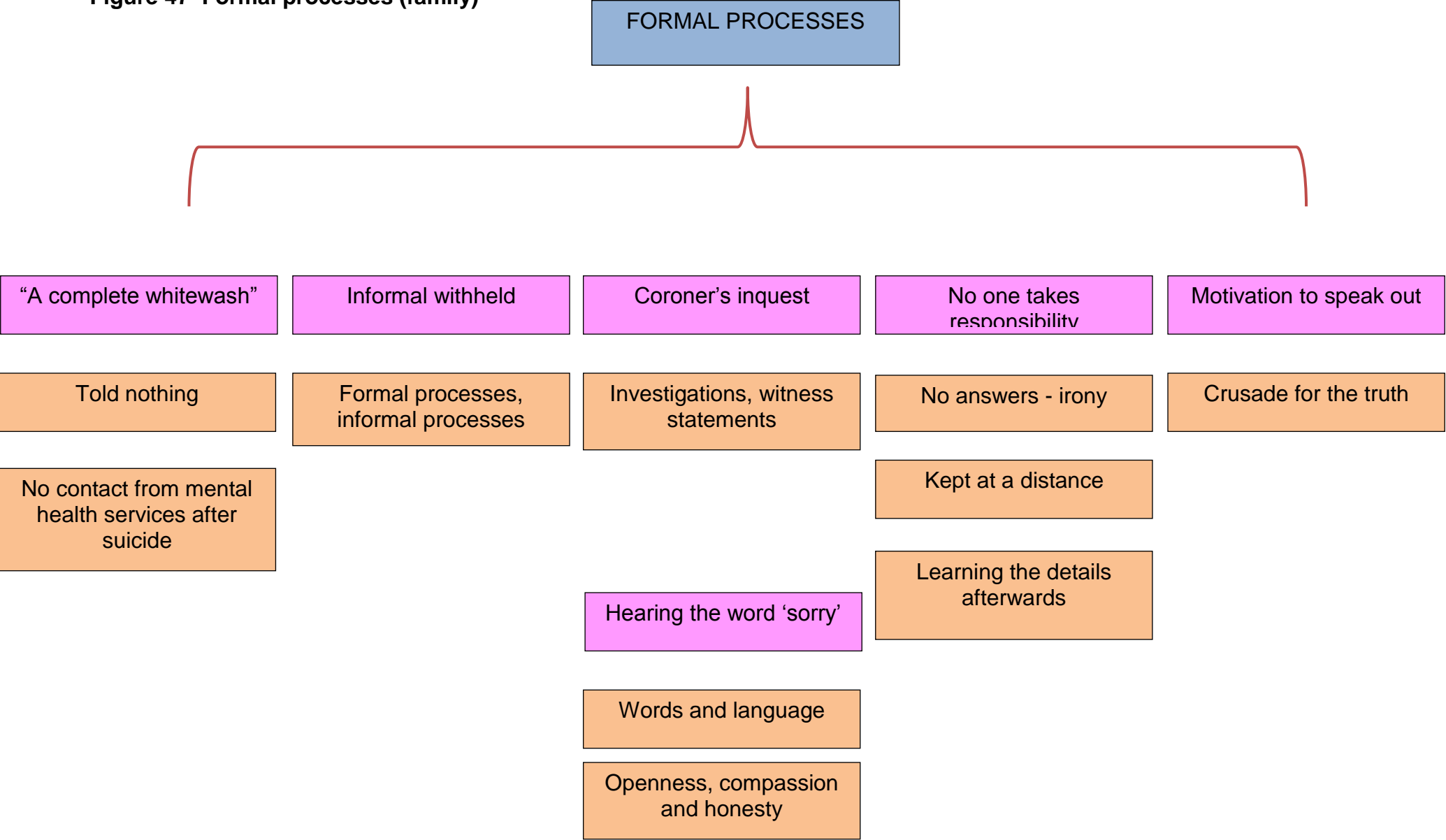


Figure 48 Emotion relating to suicide (family)

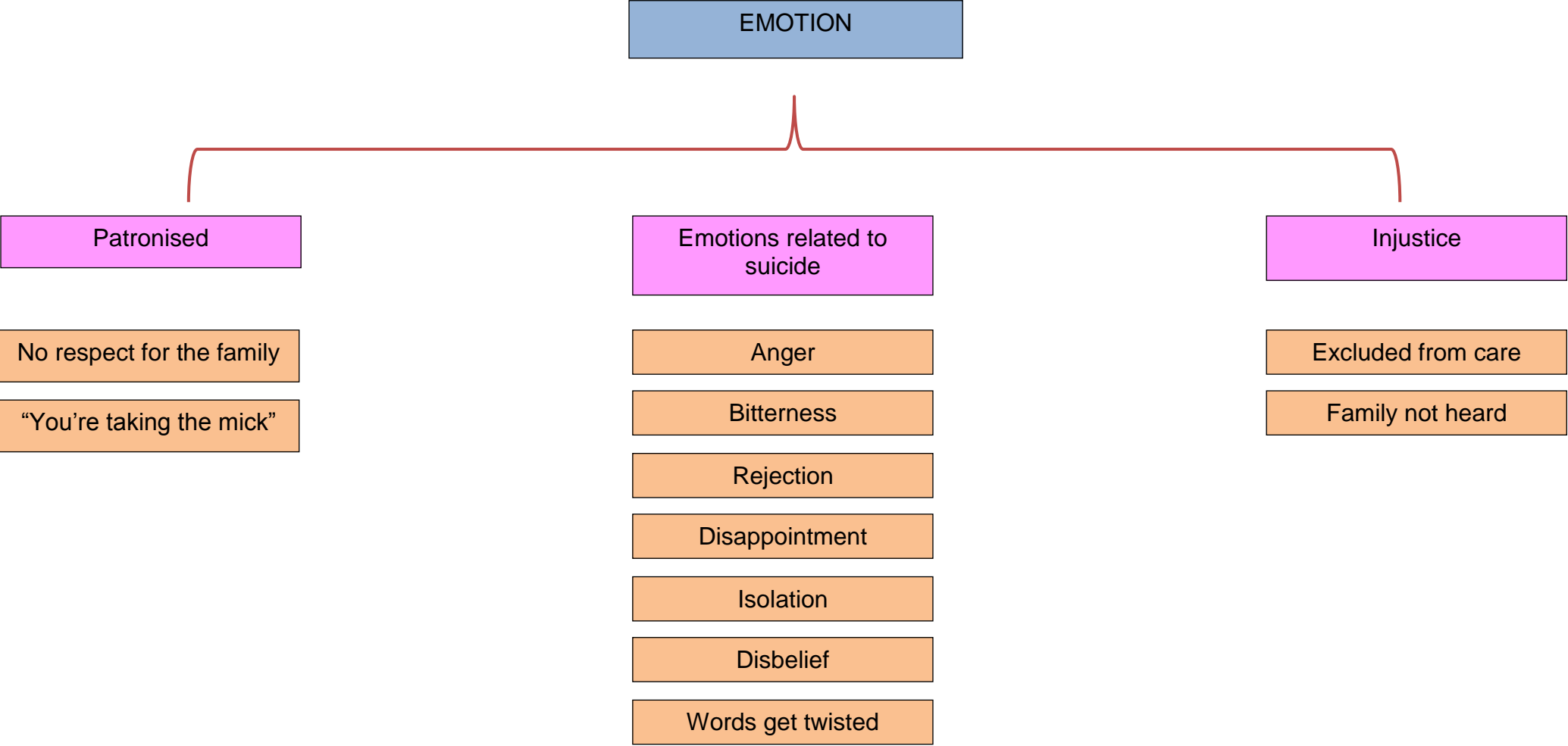


Figure 49 Family/service mismatch

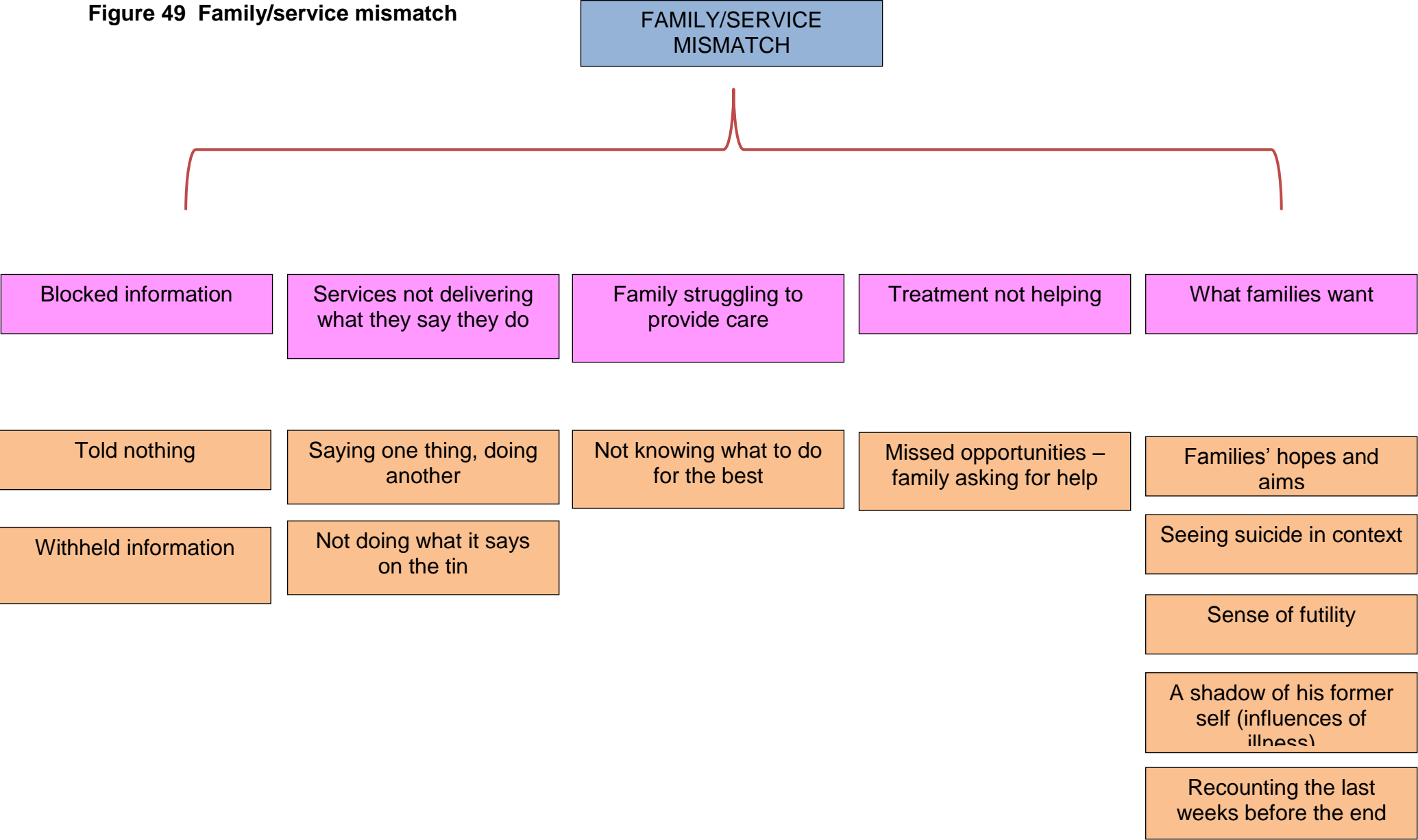
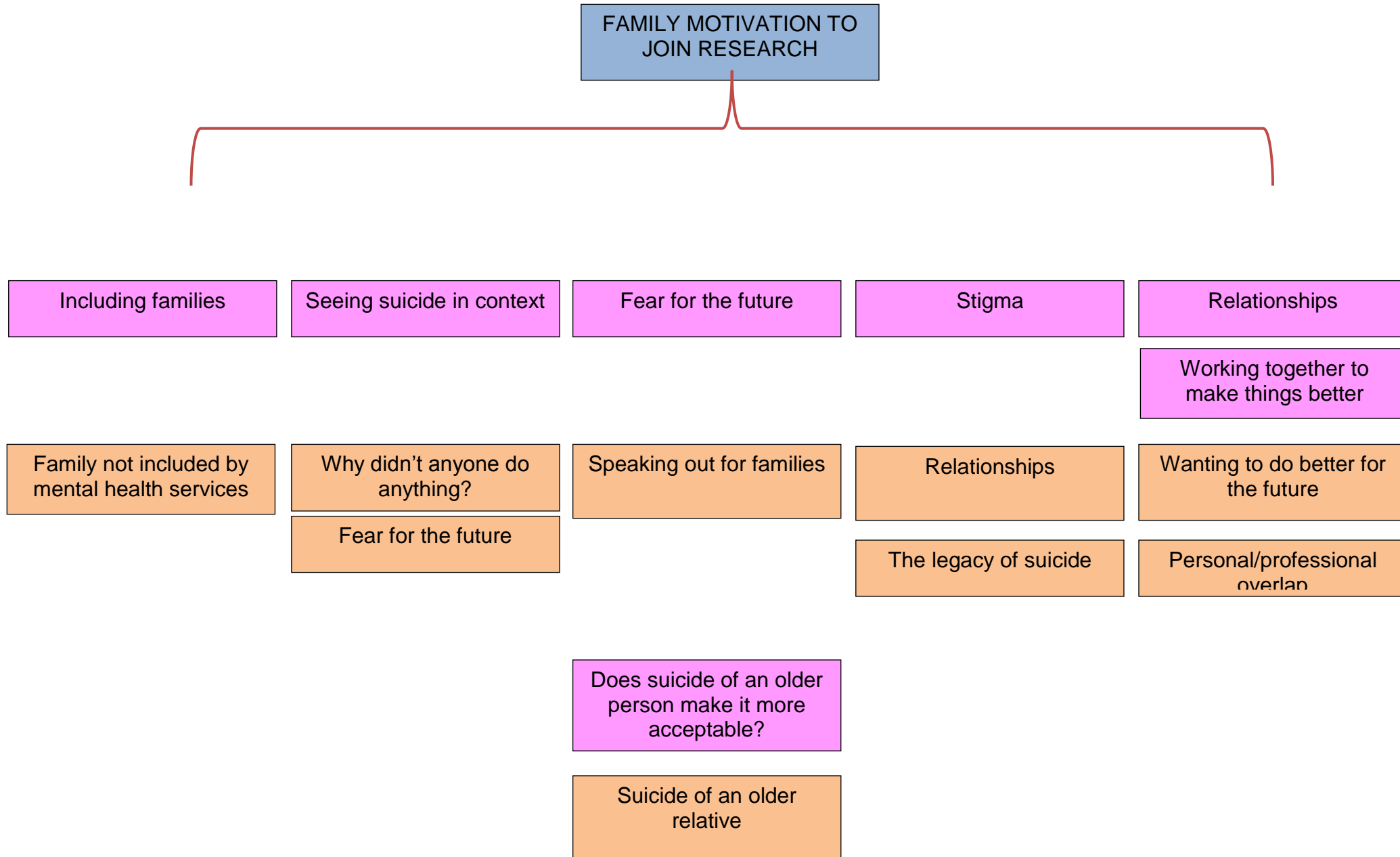


Figure 50 Family motivation to take part in research



5.5.1 Blending and bringing together core categories

Having presented the levels of analysis, together with Figure 25, Figure 51 presents the core categories from both data sets.

Figure 51 Core categories of data (both groups)

	CC1	CC2	CC3	CC4	CC5	CC6
Family Interviews	Family not being heard	Fear for the future'	Formal processes.	Emotion.	Family and service mismatch.	Family motivation to join research
Staff interviews	Training needs to...	Emotion	Breaking bad news	Including families All working together	Formal processes	Supporting managers supporting others.

The arrows indicate how the core categories are linked together; for example emotion and formal processes appear in both data sets. Further comparing and contrasting of the core categories was undertaken to check the accuracy of the data and consider relationships between the categories. I was still looking for fresh perspectives, alternative points of view that perhaps had not already been stumbled upon. Hence the core categories were approached from different vantage points. As Charmaz (2006, p. 156) suggests, when drafting a thesis, at this stage one needs to remind oneself of the theoretical framework and argument:

“You think you have an argument. The matter fascinates you; therefore, you presume that anyone would want to read it. But why should your reader care? So what?”

Returning to the research question galvanised me into asking more questions of the core categories:

- How do the core categories relate to one another?
- What do the core categories represent?

- What are the key messages?
- Do the names of the categories sum up their contents?

Some core categories seemed to connect closely from each data set, for example 'Formal processes' and 'Emotion'. However, to merge these categories might have meant losing some of the perspectives presented in each group. 'Emotion' experienced by the family members was often quite different to that experienced by staff members. Therefore it felt important to retain separate but connected core categories as I felt they clearly informed the discussion in the next chapter.

Looking more deeply at the core categories, it might be seen that CC1 'Not being heard' and CC5 'Family/service mismatch' as so similar as to justify amalgamation. Indeed one might also consider that CC2 'Fear for the future' could have been placed within CC6 'Motivation to participate in research'? And I wondered if the core categories from the staff data could be subsumed within CC5 'training needs to ...'. Importantly the stance or position taken by staff when working with patients and families, including when breaking bad news, warranted close attention. What I did not want to do from the analysis of the categories was get involved in what some researchers refer to as:

"Garden path analysis" (Richards, 1998, p. 324)

meaning presenting a list of themes and categories that are self-contained and unrelated. As the analysis unfolded, I revisited the idea mentioned earlier, by Charmaz (2006), likening grounded theory analysis to that of a skeleton, and linking with the method and design of this research, which conceptualised a framework. Here it seemed the subcategory of preparation-'training needs to'... through promotion to a core category, presented itself as the backbone of the research skeleton on which to construct and situate the findings from the data.

Taking the core categories from the staff group, 'Training needs to ...' seemed to be summed up by use of the word 'preparedness'. The core category of 'Emotion', whilst a category for both groups, could have been subsumed into one, however it seemed more coherent to retain separation from staff and family members for the reasons mentioned above. The complex and highly

sensitive process of staff 'Breaking bad news', after further reflection seemed more usefully described as 'Tuning in to breaking bad news'.

Within the core category 'Including families – all working together' it seemed one of the most important issues was that of explaining and sharing with the families risk and treatment. Therefore 'risk' was added. The core category 'Formal processes' was amended to 'Formal process following suicide for families and staff', in order that the full meaning of the category was not lost. Within the staff data a common theme appeared to be a lack of support, so 'Supporting managers, supporting others' was added. Figure 52 shows how the findings became organised within a conceptual framework of a skeleton, taking the idea from Charmaz (2006).

Figure 52 Conceptual Skeleton to show the ‘backbone’ of the findings.



The figure above shows the backbone of the findings, which was ‘staff preparedness’ and its components as the ‘ribs’. Within the core categories from the family members, the category ‘Family not being heard’ did not make mention of ‘voice’, which was an essential part of this research. Consequently this was added and the category ‘fear for the future’ became an amalgam of ‘Legacy of suicide’ and ‘fear for the future’. Much misunderstanding emerged from the expectations and aims from families for their relatives and the way mental health services delivered care. The mismatch was clearly evident and the core category name: ‘Family service mismatch’ served this well. With the core category about the ‘family motivation to join the research, becoming ‘Motivation to speak out’, finally the whole issue of suicide, how it is understood and construed, was raised explicitly and implicitly. I felt the title ‘suicide in context’ signifies that learning in this area needs to continue. Having reviewed the names of the core categories, and presented the conceptual skeleton of the research, I will discuss this in the next chapter.

6. Discussion

In this chapter I discuss the findings arising from the research analysis.

- First I will discuss the summary of the findings in relation to the introduction of this thesis, the literature, design and methodology
- Next I will include an evaluation and critique of the research, with ideas for further research
- Personal reflections will follow with some implications for systemic practice
- Finally I will present recommendations based on the findings

The previous chapter presented the analysis of the data from the participants which resulted in returning to the method and design of the study, whereby reference was made to the conceptual 'skeleton' (Charmaz, 2006) as a framework on which to arrange the research findings (Figure 52). The central tenet of the findings, that of staff 'preparedness', lent itself well to being situated as the backbone. I am therefore beginning this chapter by discussing a summary of the findings in relation to the research question:

“Research into the experience of the relationship between the family/carer and mental health staff after suicide. What are the implications for mental health services?”

The findings suggest this question can be answered quite simply:

The experience of the relationship between family/carer and mental health staff is poor and requires much more care and attention.

The second part of the research question:

“What are the implications for mental health services?”

Could be responded to by suggesting ways that mental health services can try to address the ailing condition of relationships between the family/carers and the staff within the organisation.

However, within this study many other questions have been raised. There are layers and levels of responses which I will discuss after first presenting what the family members have said they want when a suicide happens.

Figure 53 What families want after suicide

- Staff from the mental health service, one who knew the relative and someone from the organisation in the appropriate role (in a managerial position or the psychiatrist caring for the deceased) should make contact with them as soon as possible after their relative's death
- An identified point of contact at the time and thereafter
- Staff to be open, honest and give a sincere apology, say 'sorry'
- Staff to explain honestly what happened and provide answers
- To be included in the investigation to review the circumstances of death and the care their relative received.
- Families want information about the support that is available to them at the time and afterwards both nationally and locally
- Families do not want to have to wait to hear information until they go to the Coroner's Inquest
- Families wonder if there is a way for the organisation to mark the death of their relative in the form of a remembrance book, tree, stone, etc.

The above information summarises what the family members interviewed talked about. Reflecting on this, it seems to me these requests are not unreasonable. Apart from the last two points, about a delay in hearing information until the Coroner's Inquest and suggestions about some sort of memorial, all of the above form part of NHS policy, for example 'saying sorry', without fear of being sued unless proven negligent (NPSA, 2005) as shown in the literature review.

To summarise the list above may be usefully divided into three, whereby families want the following:

1. Consistent caring contact
2. Clear, timely and honest information
3. A personal and human response from the mental health service

The findings revealed a wide gap between family expectations and what was provided, and posed the question: what has happened about the recommendations in policy and why is the gap so wide? This chapter goes on to discuss this more fully.

Within this chapter information from the findings, literature, and my thoughts and reflections are blended and woven together akin to the 'Braided challah'

(Hoffman, 2000) whereby strands of precious information and experience are metaphorically melded together to create a rich and special bread.

Taking first the issue of emotion, which pervades much of our social interaction as well as our private internal dialogues, I wonder how much we think about what we say before speaking. According to Dallos & Draper (2000, p. 143):

“It is possible that much of the time we are unaware of some of the dominant assumptions that shape talk and beliefs about emotion.”

The use of words and language is relational; therefore meaning can be conferred over time, culture and context, bearing in mind:

“Sometimes unintended words and meanings can become anchored and extended in the ‘taken for granted’ or seemingly non-negotiable relational interaction” (Bird, 2004, p. 83)

Talking and thinking about emotion represents a large part of this research project, whether with staff members or bereaved relatives. Social constructionist literature invites us to question not only our conscious overt beliefs but also our implicit assumptions or ‘common sense’. As Fredman (2004) argues, emotion may be understood to originate from ‘within’ a person, be created between persons, or come from elsewhere outside the individual, depending on the way it is viewed. It is therefore by definition relational.

Talking about emotion in relation to family members, taking for example the suicide of Chrissie’s mother, which she seemed more accepting of, compared to the suicide of her son, which was still very shocking to her. This would appear to fit with theories about age related to loss of function, and link with literature about people exercising existential choice when no longer able to do what they want, and perhaps feel themselves to be a burden (Kjølseth et al., 2010). Other emotions experienced by families included feeling misunderstood, dismissed and patronised, combined with anger, disappointment, and deception. I was aware that care needed to be exercised when naming and understanding the meaning of emotions, (Fredman, 2000). The emotions the families spoke of were echoed in the literature, (Cavill & Leggatt, 2010).

By taking the relational discourse of emotion, Fredman (2000) acknowledged that we do not start from a position of sharing a common language that accurately represents our experience. The initial analysis of the staff members’ emotions revealed a multitude of experiences; however by separating each one from its context, the words became almost meaningless. Through continued

analysis emotion was contextualised once more, in slightly different ways, which when considered through the positioning compass (Partridge, 2010) provided something closer to a relational understanding. This seemed to resonate more with the literature about the impact of suicide upon staff and the potential to experience trauma and become unwell themselves (Little, 1992; Joyce & Wallbridge, 2003; Rycroft, 2004; Hendin et al., 2000; 2004; Grad, 2005). What struck me was that staff working with patients and families who may have been suicidal or ended their lives needed to know the kinds of feelings they may experience if a suicide happens: for example, shock in the hours and days shortly after the suicide and later feelings of anxiety, fear, shame, anger and guilt, which sometimes may be followed by illness. These emotions may for some temporarily compromise their ability to function, to provide care to others, and in the longer term, if not well supported, might seriously affect their ability to work in caring professions.

This information is important when considering the needs of staff, which are often unmet, particularly those of senior staff. This was often mentioned in the staff interviews. Whilst supporting and managing staff is part and parcel of a manager's every day work, Zoe and others wondered who supported them and the relative isolation they might have experienced. That said, it may be true that senior staff and managers have a slightly different set of needs, particularly when faced with relative isolation of management roles.

The majority of staff interviewed occupied a senior position in the organisation, however only one expressed the feeling of being supported. Will introduced a sense of irony when he made a comment about 'expecting nothing' and having had his 'emotion cut out'. This was poignant and exemplified his sense of being alone. In the intervening weeks and month after the research interview, Will's levels of stress increased, then he suddenly vanished from the workplace, an incident that became shrouded with gossip and speculation. Some time later Will was understood to be on long term sick leave and consequently never returned to work, thus ending a very long and prestigious career in the NHS. Subsequently I reflected on the literature about policy guidelines and social defences against anxiety (Cooper, 2010; Menzies-Lyth, 1959), contrasted with the emotional experience of a traumatic event like suicide, which it would appear there was little consideration of.

Emotions require acknowledgement otherwise there may be undesired consequences such as staff feeling misunderstood, struggling to focus on their work and possible longer term health problems. Hendin et al. (2000; 2004) found that one third of professionals experienced severe distress when a patient ended their life, which continued for a year in some cases. Keith gave a stark example of the impact of suicide when he spoke about his experiences of deep shame when faced by the family of the deceased in the Coroner's Court. This experience was rated as one of the worst days of his career. This is mirrored in the literature (Rycroft, 2004; Begley & Quayle, 2007). Certainly robustness and carefully considered words are essential in the instance of managers communicating with family members after the suicide of their relative. This fits with the recognition of the necessity for a shift in the culture of care services to provide systems and space to support and prepare staff in accordance with the roles they practice and the policy that exists.

Whilst a variety of guidelines exist to provide structure for support after the suicide of a patient, it is debatable whether these guidelines are used by organisations. Speaking from my own experience, support for staff in the aftermath is patchy and inconsistently understood or acknowledged. It seems to me that the emotional experiences of staff become lost or silenced within the margins of policy, even though information about the impact of suicide exists. This is really important for staff and managers to know and be aware of, which led me to wonder whether this information is readily accessible. Indeed, if staff could be helped to feel more prepared, and if they had more training and support for dealing with and breaking bad news, this might also provide better support for the bereaved.

Training programmes that involve thinking about what staff might expect to feel would put them in a better position to communicate sensitive information. Organisations have a responsibility to provide training, supervision and support, however as shown in Chapter 2 service policies can constrain these practices. For example policy informs us that working with families is routine practice (NPSA, 2005) involving patients and families as experts by experience (CQC, 2015), which mirrors the principles within the Triangle of Care, Carers Trust (2010; 2013), however the findings from this research present a picture of families being excluded or dismissed.

This was borne out when the CQC evaluated people's experiences of help, care and support during a mental health crisis (CQC, 2015), where the family's knowledge and experience of the situation seemed to be undervalued. Is it not surprising therefore, considering how ill prepared staff feel about contacting or supporting families, that the experience does not go well. Indeed, I recall a staff member describing a conversation with the parents of a young person who had ended his life, closing the conversation by saying, "have a nice day." In the investigation of the complaint that followed, this poor consideration of words was found to have compounded the family's grief, which could have been avoided with some thought and preparation.

In 2001 the Department of Health recommended staff training for adverse events and routinely sharing information with families following a suicide. However this message appears to have been lost or diluted, as shown in the literature. Families want to be involved, listened to and supported with their relative's care and treatment (Stanbridge & Burbach, 2004, 2007). Findings from this research found families often spoke of feeling that they were not listened to, heard or included in their relative's care.

As White (1997, p. 11) states:

"When a person enters the culture of the professional disciplines they are confronted with a shift in what counts as knowledge."

The opinions of professionals in organisations tend to dominate decision making. Family and carers are often marginalised and disregarded. So this leads me to wonder what has happened to the government's suggestions. Policy and guidance does not seem to be delivering the desired results, therefore a different approach is required. Although revised policies and new guidelines are unlikely to cease. Reviews of the quality of risk assessment prior to suicide and homicide (NCISH, 2013 a), and how mental health services which implemented key recommendations, (DoH 2001) had lower rates of suicides than services that did not (NCISH, 2013 b) are good examples of this. Cooper & Lees (2015) argue that a more psychosocial framework of understanding is required, taking account of the patient's family and social circumstances.

As referred to earlier, through the relational discourse of emotion (Fredman, 2004), meaning is co-constructed by people within a community. Therefore

relational emotion practice focusses on constructing and coordinating with others to create stories or accounts of emotional experience (Burr, 1995). This approach provides clues about how different discourses of emotion inform how we experience our feelings and how we act and interact with others. When considering the highly complex endeavour of communicating with families and breaking bad news, I wonder whether it might be prudent to consider Shotter (2015, p. 138), who advocates:

“A set of exemplary experiences that will provide us with a structure of anticipations as to what to expect will result from our action within our living, responsive relations to our surroundings”.

Developing the notion of ‘attunement’ (Shotter, 2015) further, I was reminded that when talking with families consideration of what works and what does not is important. When communication goes well people feel like they are on the same wavelength, or frequency. Consequently we should attempt ‘tune in’, which fits well with the Yvonne’s words:

“It’s not what you say; it’s about how you are.”

Whilst the attributes that Yvonne possessed probably cannot be reproduced and transferred to others exactly, I wonder if this provides a coherent platform for some meaningful guidance on communication. We would not want to communicate with families in a mechanistic way, say by reading words from a script, but an aide memoire or crib sheet could be of value. Without doubt any opportunity to think through what words to use and perhaps rehearse with colleagues the words that might seem most appropriate, may be helpful.

Chrissie mentioned that she did not hear staff saying “sorry” and this was reiterated by other family members. Tina said that families felt ‘patronised’, that a wall was erected by the staff, which was borne out in the limited literature (Cavill & Leggat, 2010). This is a tragedy because it may lead to mental health staff missing out on so much important information. Therefore feeling misunderstood and not heard, it is no surprise that the emotional responses of the family members ranged from disbelief to anger, disappointment and bitterness.

This links with what Burnham (2012) advises, about how staff might practice how they ‘voice’ words and use language in a sensitive way. Likewise this blends with Shotter (2015) who suggests a stance of ‘attunement’ and having

ready a set of anticipations, which could also be woven together with Fredman's (2004) theories about 'preparedness' and 'pre-supposing'. This then fits with the idea that staff should be prepared when communicating generally with patients and their families, but even more so when making contact and offering support within the context of breaking bad news. Zoe talked about her experience of feeling ill-prepared for the multiple needs that she found herself attending to after the suicide of a patient, the family as well as the staff's. Even though Zoe had many years of experience and had been in the position of breaking bad news many times, she said:

"Every circumstance is different; each time has a different impact ... it felt for staff like needing to start from scratch."

Consequently the backbone of the conceptual skeleton encompasses 'preparedness' indicating the need for staff to have a sense of what to expect emotionally, and how to communicate well to family members after a suicide. Action is required to prepare staff to work in ways that include the families of patients receiving care and integrate the knowledge that exists within those relationships. This is an area where systemic and family therapy can offer much to the ongoing development of staff.

Recent literature suggests alternatives to current treatment approaches which differ from the traditional medical model. As mentioned earlier, research undertaken by SANE in 2013 (Gibson et al., 2013) concluded that three things might increase a person's vulnerability to suicide: lack of a sense of worth, lack of trust and exhaustion, in combination with stresses, these factors result in an increased vulnerability to suicide. Staff working within mental health care settings need to know this information and be able to work with patients and families in ways that help to open up conversations about these important areas. The emphasis placed on a person's psychological and social context in relation to suicide is gathering weight, as shown by Rasmussen et al. (2014), who highlight the particular susceptibility and vulnerability of young men having difficulty dealing with being unsuccessful or feeling rejected. With growing knowledge about the role of culture and gender (Kizza et al., 2012), and changes in traditional gender roles, there are now many studies exploring factors associated with suicide other than mental illness. This was shown when Owens & Lambert (2012) concluded that in the pursuit of the 'medicalisation' of

male and female distress, the coupling together of mental illness and suicide research might exclude more cultural and contextual understandings.

Smith (2010, p. 187) quotes the 'London Depression Intervention Trial', (Jones & Asen, 2000), which argues that depressive behaviours are primarily maintained by the various contexts in which the depressed person is a part, including family, partners, social context and the services from which they seek help. This perspective differs from the view that depression is a personal and individual experience, and would support interventions based on understanding depression in a social context (Marsh, 2010). There is considerable evidence to suggest that by including families in the care of a relative, staff may have the opportunity to consider cultural influences through competence and awareness of the Social Graces, (Burnham et al., 2008; Burnham, 2012). This is important when viewing a person in their context, indeed working with and including families as well as the patient improves relationships and information, which in turn might prevent a suicide happening as well as improve the experience of care and treatment for that person and their family. This therefore supports the need for staff preparedness and fits neatly within the conceptual skeleton.

As shown previously there is a dearth of NHS policy about what should happen after a suicide. Following damning reports by Francis, Keogh and Berwick (2013) the NHS was urged to abandon blame as a tool and trust the goodwill and good intentions of staff. However organisations continue to defend themselves against anxiety by using performance management strategies, auditing, setting targets, having endless inspections and generally getting bogged down in public service bureaucracy (Cooper & Lees ,2015). That said, 'the professional duty of candour', (GMC, 2015; NMC, 2015), heralded a difference in the way that formal processes could be conducted. However Burnham (2012) cautions the use of 'openness' in a blanket sense, if applied without curiosity and reflexivity. Here I would draw attention to the importance of the weaving in and blending together of policy, feedback and the voices of families and staff to reach an 'openness with meaning'.

Having identified a gap, it is probably irrelevant what name is ascribed to it, what matters is what we do about it (Krause, 2012). Ultimately, families want to be included in processes and want answers about what happened during their deceased relative's care. Extensive literature shows what is useful and supportive for families following a suicide. McNenamy et al (2008) described

how family members might be experiencing symptoms of depression, guilt, anxiety and trauma. This clearly links with the findings of this research, where both Chrissie and the members of the Bond family spoke of their fear for the future, and the 'domino effect' or possible 'contagion' related to suicide. The fear of the survivor attempting or completing suicide themselves (Worden, 1982) is also echoed by Andriessen (2006) and Visser et al. (2013). Information such as, 'Help is at Hand' (Hawton et al., 2008), was found to be helpful to bereaved families, however family members in this research disclosed that this was sadly lacking.

Whilst a formula or script for breaking bad news is advised against (GMC, 2015; NMC, 2015) some guidance and back up material seems wholly appropriate and prudent. As Fredman suggests (2004, p. xxi)

"Everyone has to anticipate future death in their life, for example parents, grandparents etc. The need to explain death to children challenges the adult to bring into open thoughts and beliefs that may have not been articulated before."

However, what training or preparation do staff receive in talking about death? Begley & Quayle (2007) described attempts by family members to control the impact of death on other family members, which was apparent when members of the Bond family spoke of telling the grandchildren that their grandfather had died from heart problems. Similarly Chrissie did not want to press her sons to talk about the death of their brother, in order to protect relationships, thus being silenced as shown by Maple et al. (2010). Bowlby (1980) claimed that some parents may shield children from their feelings about death, because they are too painful to discuss. Stigma associated both with mental illness and suicide was apparent, combined with what Chrissie referred to as the 'domino effect of suicide', a fear for the future and the legacy of suicide. Indeed relatives spoke of a sense of 'purposefulness' following their relative's suicide, in that they were searching for what they felt to be the 'truth' about what had happened.

This seemed to motivate family members to participate in the research. Lakeman & Fitzgerald (2009), Biddle et al. (2009) and Moore et al. (2013) report that research activity might actually benefit family members bereaved by suicide. My hope was that through listening sensitively to what people had to say, something positive might emerge from the tragedy. When I made contact with Brenda, Brian's widow, she was able to tell me that the Christmas that

followed the research interview was the most peaceful the family had had since Brian's death. Whilst it is not possible to be definite that the interview was the cause of this, I hoped that the process provided some kind of catharsis for the family, which might have aided the process of recovery and healing (Tomm, 1987). This reminded me about what might be revealed by working with dilemmas, as described by Partridge (2007 p 98):

"Diamonds in the dust."

Despite their losses and the difficult emotions that accompanied their experience, I was heartened to see that Chrissie and most of the Bond family members appeared to have an understanding of the pressures on the NHS and mental health services. However all reported that the services said one thing but did another, and seemed to be of the view that the treatment being offered was not what was needed by their relative. It therefore came as no surprise when this was reflected in the recent evaluation of crisis services in the mental health care setting (CQC, 2015).

Families that include someone with a mental illness generally seek help from services with high hopes that the health and welfare of their loved ones will be met with care and treatment of the highest standard. Family members state they want to be included as part of the plan of care for their relative. Research and guidance exists about how best to include families, (NCISH, 2013; CQC, 2015; Stanbridge & Burbach, 2004; 2007) and how staff can utilise the great bank of resources about their relative that the family has.

Nonetheless despite having high hopes as time went on and the experiences received were felt to fall short of what was expected, family members concluded that staff were missing the important points and not communicating with them, which resulted in the feeling that there was a mismatch in family/service needs. This links with the literature, which showed that despite the families voicing their safety concerns, their relatives were not admitted to hospital, treatment interventions were too brief, discharge was premature and post discharge support was not provided, (Leggatt & Cavill, 2010).

In the case of Mr Bond, who declined to consent to information sharing with his family members, the issues of patient consent and confidentiality appeared to get in the way of developing a therapeutic alliance with Mr Bond, his family

members and staff from the mental health service. However with guidance, as referred to in the page previous, it is possible to work with patients and families when consent is with-held by listening and bringing together segments and details of information that perhaps would be known in isolation and until brought together, and reflected upon, provide another more inclusive and comprehensive perspective to inform the care required, including the risk of suicide.

Had Mr Bond consented to information sharing with his family, or at least one member, I wonder whether this would have made a difference to the relationships and therapeutic alliances that might have developed. Furthermore clear direction for staff about what to do and how to share information when consent is absent exists and needs to be readily available and accessible to staff who feel confident and competent to act accordingly.

Likewise could staff have worked harder to engage Mr Bond and his family? A dearth of literature is available about ways that staff can develop trusting and therapeutic relationships with patients. For what ever reason, the staff involved in the care of Mr Bond sound like they were ill equipped in addition to the fact that staff members changed and services were inconsistent throughout. Essentially it seemed that not one staff member had managed to get a sense of what was happening for Mr Bond and therefore what might help to make a difference for him. Indeed the literature indicates in crisis, people felt the response by the mental health services to be unsatisfactory and challenged providers to ensure staff have the appropriate skills to meet the needs of people in crisis (CQC, 2015, p 12).

Likewise, had staff been consistent with Adam, Chrissies son, would they too have been able to know more about what factors might influence the increasing likelihood that Adam would end his life. This links with research into adequacy of risk assessment, whereby clinicians ignore past history, relying on generic plans of management, which lack individuality to the person (NCISH 2013, p2). In addition the absence of a meaningful therapeutic relationship in both of these cases is reflected in the literature from Leggatt and Cavill (2010) and the CQC (2015).

This research set out to listen to family members and mental health staff talk about their experiences after suicide, and in doing so, what become clearly

apparent throughout was the isolation and loneliness that individuals experience after suicide happens. This was very much the case with both staff and family members who spoke of feeling silenced and alone. It felt natural to turn to those people and their voices that created the findings in choosing a title to this thesis; consequently the title; “lonely voices”, seemed to sum up the study which reverberated loud and clear.

Referring back to the beginning of this thesis, I used two introductory quotes, first from the mother of Natassya:

“With one thing, the coronial inquest was right; she was “extraordinary”. Our beloved daughter was indeed extraordinary and we have to come to terms with her loss, a loss that is still hard to comprehend and still seems to have been entirely preventable....at least, at that point in her life. Natassya took her own life when she was 19 years old...” (Nichterlein, 2013, p. 30).

And next came from therapist Donna James;

“I found it risky to divulge, when asked how I was, the still tender feelings about the suicide and how I was working my way through my reactions ... I talked about having had two other suicides earlier in my practice, and how I was still reeling from the effects of this one ... Yet there was lingering silence as there always is at these moments when I have just told, just enough silence to leave me wishing I had not exposed myself. I should have left them guessing about the tired sadness in my face”. (James, 2005, p. 17).

Families and their relatives come to mental health services for help. Staff invariably strive to do a good job. Nonetheless suicide happens. It is therefore important to acknowledge from both positions, staff and family members, that suicide is a tragedy having profound effects on all involved. In June 2015 ‘Openness and honesty when things go wrong: The professional duty of candour’ (GMC, 2015; NMC, 2015) was launched, however findings about what families and carers say they need from services have been largely disregarded. The most recent strategy for Preventing Suicide in England (DoH, 2013) consists of the following:

- Reduce the risk of suicide in high risk groups
- Promote mental health and well-being in the population as a whole
- Reduce access to the means of suicide
- Provide better support for those bereaved or affected by suicide

- Support the media in delivering sensitive approaches to suicide/suicidal behaviour
- Support research, data collection and monitoring

This clearly placed the provision of better support for those bereaved or affected by suicide in a much more prominent position, and called for improvement in the culture of care and the need for compassion to be shown and upheld by staff. It strikes me that this constitutes more of the same in terms of policy providing a defence against anxiety. Perhaps this is illustrated in the conceptual skeleton, by a lack of a heart, or a heart that is underperforming. Addressing such a vast concept goes beyond the remit of this thesis, however it has been important to acknowledge that this research has shown that the staff working in mental health services feel their needs are not being met, and this in turn may have a bearing upon the care they deliver.

The need to see suicide in a broader context has been highlighted throughout this study. More recent literature presents the subject of suicide from a number of perspectives other than the medical model. The literature challenges the myths associated with suicide happening mostly within the context of a mental illness. This creates space to explore more fully and improve understanding of other influencing factors. Therefore developing awareness and understanding that suicide happens within and outside of mental health care might assist families with gaining a broader perspective of what is possible and perhaps not possible within healthcare. This may also help temper expectations that all suicide can be prevented.

Indeed Chrissie alluded to this herself when discussing the suicide first of her son and then her mother. I was thankful that Chrissie had been able to reflect in ways that opened up possibilities about why people take their own lives. However, I am aware that this capacity to reflect and see things from different perspectives takes time and a whole host of other attributes, including exploration of spiritual dimensions and generosity through being able to forgive, which may never be realised. The knowledge of what families say they want, now enshrined within guidance from the GMC and NMC (2015), matched with findings from staff members, and created the spine or backbone of the conceptual skeleton, 'preparedness'. That some staff working within the organisation feel ill equipped to contact or offer support to families who have

experienced the suicide of their relative, on the face of it might suggest that training in this area will resolve the problem.

However I would like to unpick this a little more, as providing recommendations about training staff to break bad news is something I have already been involved in. The findings highlight a variety of different areas that require attention, signified within the skeleton as the ribs radiating from the spine. Depending how you see it, one might ask where is the heart within the skeleton? We may yet discover the heart.

As this is a systemic piece of research I am interested in relational influences and seeing ways that the research question might be addressed through relational discourses. Whilst issues of commissioning and organising services, manpower, training etc. are important, what cannot be ignored are the basics in terms of communication and relationships. Indeed reflecting upon what,

'Preparedness of staff'

might mean to me it seems that it is not about when suicide happens; it is more about a culture within which suicide may happen. Here I am attempting to articulate the importance of good quality and compassionate care as routine practice, which actively involves the service user/client and their family in care from the outset. I am not advocating this 'just in case' suicide happens, however if suicide does happen, the existence of good care and relationships may make a difference to the way the aftermath and impact of suicide influences those affected.

Family Therapy/systemic practice suggests that when relationships are well established with families and carers, when they consist of regular contact and communication with main family members, and involvement in care plan reviews, treatments, and clarity about who to contact routinely or otherwise, traumatic events such as suicide can be supported and explored.

Without doubt, continued research is required in this area. The research findings have highlighted the need for staff preparation in a number of areas. As Shotter (2015) suggests, I am advocating recommendations that provide a structure of anticipations about what to expect when a traumatic event occurs and what we should do. My concern, however, is whether organisations will

implement these recommendations in the spirit they are intended, or whether defensive bureaucratic procedures will take their place.

6.1 Recommendations

The previous section discussed the findings from this research and were arranged within a framework of the conceptual skeleton. This section develops the findings further and presents the following recommendations:

- 'Preparedness' – staff training is needed to prepare them for 'tuning in to breaking bad news'
- Families need to be included and considered partners in care before a suicide happens

Recommendations after a suicide has happened:

- Staff training and 'preparedness', including time and support with 'tuning in to breaking bad news'
- Families have 'appropriate' contact from mental health staff based on honesty and openness, inclusion in investigations, support and information
- Families and mental health staff working together to make things better
- Developing greater understanding of suicide in context

The figure below sets out recommendations I am making to address the gap identified from this research.

Figure 54 Summary of the results of what families want after suicide

	STAFF	FAMILIES
DURING CARE	<p>Training – ‘preparedness’ for ‘Tuning in’ to breaking bad news</p> <ul style="list-style-type: none"> ○ What to expect – (yourself, from/for families, staff, managers, organisation, etc.) ○ Emotions ○ Words ○ Resources ○ Support ○ Time <p>Guidelines for working with families – Triangle of care. Consent/confidentiality, Professional duty of candour, Including families in care, Discuss risks/benefits of treatments</p>	<p>Inclusion of families in care from the outset</p> <ul style="list-style-type: none"> ○ Care planning, reviews and discussions. ○ Risk assessment ○ Joint aim of care <p>Communication with patient and family-(Triangle of Care & Duty of Candour)</p> <ul style="list-style-type: none"> ○ Listen/engage ○ Believe ○ Utilise knowledge ○ Explain services ○ Open and honest ○ Do what you say
AFTER CARE	<p>Guidance and support with breaking bad news; incorporating the Duty of Candour – ‘tuning in’ to breaking bad news</p> <ul style="list-style-type: none"> ○ Time ○ Who (in person, face to face, 2 staff, include manager and staff that knew the patient/family. ○ How ○ Language, “sorry” ○ Provide information ○ Providing support for family ○ Providing support for staff and manager ○ Investigations/inquest 	<p>Family receive contact from mental health service by staff who knew the patient and senior staff in person</p> <ul style="list-style-type: none"> ○ By phone, in person etc. ○ Communication by an ‘appropriate’ staff member ○ Language/words ○ Sensitivity/compassion ○ Honest/open; saying “sorry” ○ Provision of information ○ Provide ongoing identified point of contact and support ○ Inclusion in investigation inquiry ○ Access to information and outcomes ○ Remembering the person who died

The above recommendations set out the findings from this research and taking each quadrant at a time I would like to explain as follows:

Staff 'preparedness' is recommended in the following:

- Awareness in cultural competence

Training and raising awareness is recommended for appreciation of cultural differences and complexity, thereby improving the competence of staff within the organisation. This could take place through the Social 'GRRACCEESS' (Burnham et al, 2008; Burnham, 2012). This recommendation is for all staff at varying levels, depending on their particular role, which would include use of words and language to develop appreciation of culture, context and difference. This sits with guidance from the GMC and NMC (2015).

- Preparing staff to work in ways to actively include with families and carers

The literature informs us that working with families as routine practice, involving patients and families as experts by experience (CQC 2015) usually assists positive relationships and effective communication. As borne out by these research findings, the recommendations mirror the principles within the Triangle of Care Carers Trust, (2010; 2013) through preparation of staff in the following areas:

- Set out and explain clear routes of accessing and exiting mental health services, including routine and urgent, crisis contacts etc.
- Working with families to include issues of 'confidentiality'
- Sharing treatment plans and risk with family at the start of treatment and regularly throughout the course of care
- Sharing potential risk with families of suicide in and outside of the context of mental illness
- Sharing information with families about the potential risk of suicide which often happens in context of other factors (psycho-active substances, impulsivity, psychosocial etc.)
- Sharing uncertainty with families and the fact that we cannot definitely know who will end their life, link with mental illness/suicide
- Widening understanding and viewing suicide in a broader context
- Preparing staff to communicate with honesty and compassion

The importance of the basic components of communication, including both verbal and non-verbal, is recommended, including use of language and words which show respect, appreciate and considers cultural and other contexts. Clear open and honest communication is what families want from the staff delivering care. The findings from this research show that all five family members that participated in this study were not treated as they should have been by the mental health services providing care for their relative when they killed themselves. These suicides happened after 2005 when policy advocated being open and saying 'sorry' (NRLS, 2005, 2010).

- Preparing staff by providing updated information about relevant research

Preparing staff by providing updated and relevant information and research relating to clinical practice, as well as viewing suicide in wider contexts is recommended, as it is not clear how and whether staff are updating themselves. Whilst this is in part the responsibility of individual professionals, the organisations within which staff practice and work have a duty to make sure their staff are competent. It is not clear from the findings how staff learn about research and developments relevant to their practice. Indeed the findings from the staff members showed variable knowledge.

I wonder whether it would be helpful to share with staff the NCISH annual report findings, research findings from the Samaritans (Scowcroft, 2012), Gibson et al. (2012) and Marsh (2010) which highlight people who present a significant risk of suicide within their psychosocial, economic and relational contexts. Disseminating research that presents alternatives to the medical discourse of suicide, and sees suicide in context would provide the opportunity for staff to develop awareness and practice in ways that embrace multiple possibilities and refrain from certainty.

- Staff preparation about what they might experience after a suicide happens.

There is no classic response to the suicide of a patient, however:

"It is important for a professional to be reminded that experiencing some post-trauma symptoms is a sign of humanity and not weakness" (Rycroft, 2004, p. 91).

Staff preparation about what they might experience, including potential emotions, is not widely available. It is therefore recommended that as part of training and competence of staff, what might occur after the suicide of a patient is included and discussed.

- Preparing staff about what support they can expect after a suicide

As above, making staff aware of what support they can expect after a suicide is important, 'Help is at Hand' (Hawton et al., 2008). Grad (2000) Palin (2006) and Gaffney et al., (2009) set out guidelines about ways to assist clinical staff after the suicide of a patient, presented in more detail in the literature review. There is an expectation for organisations to have mechanisms to ensure these guidelines are implemented consistently to support staff, however experiences are variable.

- Preparing staff to support colleagues, other staff and managers

The findings from this research have clearly demonstrated that staff in management positions have felt unsupported. The expectation within their role being one of supporting others, it seems their need for support has been taken for granted or overlooked. What staff need in these situations are clear support mechanisms. Whilst it might sound like I am stating the obvious, the organisation will need to acknowledge this and take responsibility before anything changes.

- Staff preparation about what emotions they may experience in families after suicide

The emotional impact after a suicide ripples far and wide. Staff may be expected to contact, visit and offer support to family members, or be called to appear in Court. This experience has been shown to be potentially stressful, and particularly distressing for some to see the bereaved family members of the deceased. However little preparation or discussion appears to have taken place beforehand. Therefore as part of the recommendations from this research I am proposing this area requires more consideration.

Whilst it might appear that I have presented a list of activities to be undertaken in order to achieve a certain standard of care, I am also making a stand for

promoting appreciation and awareness of these important areas to positively influence the dominant culture of care. Only then will it be possible to think about addressing the gap between what clients/families generally want from services with what staff from within the services provide.

Having set out the above, I propose that preparedness is needed for staff to break bad news to family members/carers after a suicide happens.

- Staff preparedness for 'tuning in' to breaking bad news

The findings from this research have shown what family members want from staff in mental health services after a suicide. This is reflected in the guidance from the GMC and NMC (2015); however the complexity of communicating with people that may be in a state of shock cannot be underestimated. Fredman (2004) offers up guidance around 'pre-supposing' how one might feel and anticipation of ways to prepare when meeting with bereft families. Whether or not all staff need to be specifically prepared for breaking bad news is debatable. Having devised and delivered training to a variety of staff, and hearing what families say they would prefer, I believe there is a need for more managerial and senior staff with enhanced communication skills. However the challenge to the organisations will be in identifying who those staff will be and how to work with them.

Returning to the main recommendations, I will discuss working with families in more detail.

- Family inclusion and collaboration as partners in care before a suicide happens

The CQC (2015) have provided guidance about the need to share risk with families at the outset of treatment. This is a clear responsibility which clinicians should take account of. Findings from this research showed that sharing risk with the patient and family members routinely happened for one staff member. However this did not seem to be case with other interviewed staff and will pose a change in the way some clinicians practice. The information that might be missed by not including family perspectives is incalculable, therefore working with cultural sensitivity (Burnham et al., 2008), and the principles of the Triangle of Care (Carers Trust, 2013) provides a useful frame of reference for working with families. Together with the professional duty of candour (GMC, 2015; NMC,

2015) and the findings from this research, there are plenty of examples of how to doing things differently, and how to blend policy with the lived experience. This is important when viewing a person in their context, indeed working with and including families as well as the patient improves relationships and information, which in turn might prevent a suicide happening as well as improve the experience of care.

- Recommendations after a suicide has happened

The preparedness of staff in providing care presupposes well-established relationships with patients and families. If a suicide takes place the staff who are charged with breaking bad news and offering support to bereaved family members, require preparation and support themselves. It is necessary for families to have appropriate contact with mental health staff based on honesty and openness, receiving support and that they are included in investigation and information sharing

The previous section discussed the findings of this research in relation to what families say they want after suicide. How these 'wants' are responded to is what I have tried to discuss in the results of this research. This will be crucial in terms of applying what has been found and trying to improve the experience of the relationship between families and staff after suicide.

The findings from family members confirmed what was found in the only research literature by Leggatt & Cavill (2010) about this subject. The failings on behalf of the services were disappointing, as were the findings from this research. It is anticipated that through developing the 'preparedness' of staff to work in family inclusive ways that encompass the principles highlighted above, examples such as these will become a thing of the past.

An important factor here, however, is the context within which suicide is understood, and the different expectations of patients, families and the community at large, about what can be provided by mental health staff and the organisations they work for.

- Developing greater understanding of suicide in context.

Through the literature review it has been possible to consider the evolution of research about suicide and how it has been seen through the ages, from the

medical monoculture towards the recognition that suicide does not only occur within the context of mental illness appreciating also the influences of psychosocial and wider culture and context. Indeed standing back and appreciating that for some people the struggles of everyday life, given certain circumstances and situations, for example when falling on hard times or experiencing profound loss or disadvantage, interventions from mental health services might not be able to make enough of a difference to their lives. How much this permeates wider society is difficult to discern, however is essential that alternative theories and types of knowledge, including those from the people most closely affected by suicide, are disseminated in the media and in mental health services, bearing in mind what happens when targets, audits, policy and regulation dominate and drown out the voices of lived experience.

To summarise, the above figures and recommendations set out the findings from this research and attempt to articulate what is sometimes hard to describe in words. The next section of this chapter provides a critique of the research endeavour.

6.2 Evaluation and critique

It is important to evaluate and critique the entire research endeavour. Deciding upon the method of evaluation led me to consider two possibilities. Having used grounded theory in my method and design, Willig (2008, p.150) proposes applying criteria from Henwood & Pigeon (1992), informed by grounded theory. However, I have selected the 'Eight Big-Tent' criteria (Tracy, 2010) as this seems to elaborate Henwood & Pigeon. Tracy (2010) presents eight criteria of qualitative quality which set out a flexible platform and provides a structure for evaluating research

- Worthiness of topic
- Rigour
- Reflexivity
- Credibility
- Resonance and clinical implications
- Contribution to the field of research
- Ethical considerations
- The process of the research
- The research question, the findings and literature as a whole, implications for systemic psychotherapy, ways forward

I will take each one of Tracy's criteria in order and close this chapter with conclusions.

Tracy (2010, p. 840) suggests a worthy topic is:

"Relevant, timely, significant, interesting or evocative."

Goldney (2013) suggests that much change has taken place for the better in the field of suicide prevention research over the last five years; however I found there was little literature on the area of the lived experiences of family, staff and carers, therefore the research question seemed timely and interesting. The literature reviewed included the subjects of physical and mental illness, national policy, patient safety, death and mourning, self-harm, suicide and family therapy. However according to this study, and also borne out in the literature, recommendations and guidance seemed to be randomly implemented. Therefore the worthiness of this project is indisputable. Indeed in terms of timeliness, the recent reports and guidance from the GMC and NMC (2015)

suggest that the subject is very much in the minds of the government and the public.

Tracy (2010) suggests research is worthwhile if it:

“Questions taken for granted assumptions or challenges well accepted ideas.”

Part of this research has indeed challenged traditional views of death and mourning, promoting Fredman’s (1997; 2004) idea that we ‘remember’ the past in the present, to enable people to create context from which they can ‘go on’. Fredman warns us that;

“Some psychological theories of experts about death have become ritualised and turned into policy and procedure for good practice ...”
(2004, p. xix).

However this research has also attempted to consider suicide in a wider context, to move away from the traditionally held views that suicide almost always occurs in the context of mental illness. Durkheim (1897) considered suicide in the context of social breakdown, combined with the potential influences of early attachments and relationships. The literature review challenged the;

“Illusionary safe certainty of psychiatric diagnoses” (Boyle & Johnstone, 2014).

However as I have said before, it would be ill advised to claim that mental illness and suicide are not linked. What I have attempted to do is promote the perspective that suicide takes place in a broader context where other influences like relationship breakdown, culture, psychosocial and economic stressors are at play. According to Dallos & Draper (2000), social constructionist approaches invite us to question not only our beliefs but also our implicit assumptions or ‘common sense’. I am advocating opening up discussion, exploration and development of beliefs and assumptions with staff and families, as a means of trying to understand the complexity of suicide.

In terms of timeliness of this study, I could not have predicted the launch of the ‘Professional Duty of Candour’ in June of 2015, the same year this study concluded. Therefore, I am convinced this research is both worthy and timely. It attempts to further the body of knowledge relating to suicide research from the perspective of the experience of relationships.

Tracy's mention of rigour refers to the use of abundant and appropriate collection of complex data and sufficient analysis. Data was collected from face to face semi-structured interviews with the emphasis on hearing the voices of people affected by suicide. Interviews were transcribed and participants invited to read and check the transcripts before analysis commenced. Being a qualitative study using grounded theory, a social constructionist approach has been used to analyse the data and the findings have been compared with field notes, diary reflections and memos, as well as the literature pertinent to the study. This has resembled what Sools (2012) refers to as big and small stories which were selected because of the opportunity to hear multiple voices. I considered other methods for data collection and analysis, for example interpretative approaches; however I settled with social construction as I was keen to foster discussion that created meaning for the speakers themselves.

This study has been sincere and reflexive throughout, with the topic being introduced with two quotes, one from Maria, the bereaved mother of Natassya (Nichterlein, 2013) and the other from Donna James (Weiner, 2005), a therapist trying to work through her reactions to a suicide. These quotes seemed to me to sum up from two perspectives the monumental impact of suicide and led me to wonder whether at some point the sharing of these experiences might be possible.

During my research into the experience of the relationship between family/carers and staff after suicide I have listened to and heard many voices from people deeply affected. I have been both impressed and appalled by what I have heard, have wanted to capture the essence of these experiences, and create something that is truly worthwhile to developing understanding in this area. At times the responsibility to do my best has felt insurmountable. As Weingarten (2007, p. 22) says:

"Reflexivity in the research process sometimes encounters the sentiment of fearing in the end whatever project was undertaken would be insignificant ..." however, 'the absence of action born out of deep caring shows up in the world no differently from inaction due to indifference.'

These words have served as an anchor for me, and have helped me remain connected with the research at times of turbulence. Reflecting and revisiting it, as I have on many occasions, has enabled me to review and evaluate this journey and my various positions and emotions along the way.

What started with blind optimism and deep reserves of energy has been tempered by a variety of things throughout six years of study, some of which I have mentioned in my summary of the analysis. At times carrying out this research has felt like living in a parallel universe. Hearing what participants have said about their struggle, feeling so futile and overwhelmed, various ideas have helped me stay connected to the work. The 'Bundle of treasures' mentioned by Partridge (2010), for example, whereby therapists invite clients and/or practitioners to reflect upon the rich stories and cultures which have influenced them. This approach of 'holding the difference without trying to resolve it', like the dynamic tension of coal and diamond, acted as a resource to spur me on, similar to the concept of Hoffman's 'Braided challah' (2000). I have found inspirational words like those of Smith (2012) when he speaks about the battle between hope and despair:

"Hewing out hope from mountains of despair" (Krause, 2010, p. 181).

My position as a researcher as well as an employee of the organisation within which the research took place has been challenging. My awareness of possessing the necessary credentials to research this subject emanated from a place of honesty and sincerity, in that my career as a nurse and family therapist, were tools that equipped me to hear the words, sit with the emotional outpourings and carry on. However one of the biggest challenges was the expectations of the organisation, which placed me in the position of undertaking investigations into 'Serious incidents requiring investigation' and presenting linear conclusions. This expectation sat in direct opposition to the thinking which has developed over the span of my career. My attempts to present conclusions that were tentative, not black and white, but more systemic, were poorly received by the organisation.

Effectively I was trying to practice what I preach in an environment that did not want to hear what I was saying. What the organisation wanted was someone to present expert opinions. When I was not able to do this I encountered a climate of resistance and silence. Theories about social defences against anxiety (Cooper, 2010; Cooper & Lees, 2015; Menzies Lyth, 1959) provided important insights into how organisations operate. Reflecting on my diary entries I can now recognise similarities to my experiences in the voices of the family members I interviewed, who had been trying as hard as they could to pass on important information but this was felt to fall on deaf ears. It is hardly surprising

that emotions start to overtake and cloud rational thinking when a person's voice is ignored or silenced.

Weingarten offers this advice:

"As long as despair does not descend into isolation, devolve into indifference, foster fear or hatred, it is just another emotion that accompanies us along the way" (2007, p. 21)

Only recently I have been able to reflect upon this issue more rationally and relationally and reach a point of some understanding. My perspective now is that I was despairing about my job and the position I was being placed in. I tried to learn how to cope with my situation by exploring positioning theory (Campbell & Groenbaek, 2010) but failed miserably and suffered as a consequence. At that time the only respite was the 'oasis' of the family therapy work I was involved in.

At this time my ability to create some distance from the demands of my work and the desire to continue the research was lost. Perhaps I became, as Weingarten suggests, isolated and indifferent. I believe this was not because of one thing but directly linked to the context of what else was going on at the time, including caring for my terminally ill father. I was not proud of the decision to end the research with the sobering thought of all the work that had taken place and all the voices that would remain unheard; however somewhere out of the mountain of despair 'hope was hewn', in the guise of a new start, a new beginning and the ability to pick up and carry on.

This has relevance in as much as it presents parallels to the research by the way persistence, honesty, hope and sincerity can 'chip' away at mountains. This was reflected in the words of Chrissie Clark and echoed in the literature:

"Small actions matter and ripple out in ways we cannot predict"
(Weingarten, 2007).

So whilst this research represents a small contribution to the subject, I believe it is important. The experiences have been rich and at times deeply moving, and I have attempted to weave them into current literature and make recommendations for future action.

Moving on to credibility, which Tracy describes as providing a 'thick' description, including multi-vocality and member reflections, this naturalistic qualitative research has been designed to hear the voices of the people most affected by

the experience of suicide. Therefore the strength and credibility of this study is borne out of the data. The people directly or indirectly affected by suicide include laypersons, carers and professionals within and outside the mental health setting. Supervisors and colleagues, formal and informal, have also contributed.

The methodology used throughout derives from a social constructionist perspective and grounded theory. The shift from first to second order perspective within systemic psychotherapy embodies the view that a researcher cannot adopt the role of detached observer. Therefore an essential element of this research has been the use of a reflexive diary, memos and field notes, with the weaving in of various influences that have made an impact upon me and the people with whom I have spoken.

The limitations to this study include the small numbers of participants, particularly family members, which means that generalisations cannot be drawn from the findings only open up ideas and suggestions for future research. However in part this was a result of the restrictions placed on the research by the Ethics Board which resulted in a poor response rate from the families that were invited, which proved very challenging. Another important factor has been my position, and the multiple roles I have occupied in relation to this study. Had I been approaching this research from a position outside of the organisation, the findings or indeed the response rate may have been different.

The findings suggest that family members of the deceased relative had a very poor experience of mental health care. Whilst this study intentionally did not pair family members with staff members who had cared for their relative, I wonder what their conversations might have consisted of, had this happened.

Tracy invites reflections on the contribution made by the research, conceptually, practically, morally and methodologically. As mentioned previously, this study is a piece of research that has not been undertaken before. Therefore as such the findings offer new insights into the experience of the relationship between families and staff in mental health services after suicide. The findings having been analysed and amassed around a conceptual skeleton, the backbone or spine of which has been the 'preparedness' of staff, closely connected to core categories, or ribs, that have been informed by the literature. This in turn informs recommendations which have been set out to attempt to answer the

research question. Resonance within this study has been apparent through the interviews with both staff and family members as well as myself as the researcher. The research findings might well be useful in other settings, such as schools, colleges, prisons, the private sector, as suicide happens anywhere and everywhere.

The contribution made by this research might be small however the ways it has been undertaken have been unique and as Weingarten (2007) argues;

“Small actions matter and ripple out in ways we cannot predict”

Were I to start again I think I would approach this research from outside of the organisation within which the suicides took place as this may engender more of a willingness by families to become involved. Indeed my hope is that more research for the future with families having experienced suicide of a relative would inform and add to the findings here. My hope is that this will connect suicide literature with relational systemic theory and build the elements of care and compassion so essential within healthcare and return a heart to the system once more.

7. Conclusion

This research title was:

“Research into the experience of the relationship between the family/carer and mental health staff after a suicide; what are the implications for mental health services?”

I introduced this study by setting the scene and referring to two quotes, one from Maria, the bereaved mother of Natassya (Nichterlein, 2013) a young woman who took her own life, and the other from Donna James (Weiner, 2005) a therapist who was trying to work through her reactions to the suicide of a patient. Both quotes are similar but also different, both seem to come from a place of emotional turmoil, and they offer perspectives on the experience of suicide, which can be shocking, brutal and offensive.

Literature abounds into the what, where and who of suicide. There are many papers which attempt to gauge risk and offer demographics of those believed to be at increased risk of ending their life. This has been followed by a significant amount of policy and guidance about how organisations need to respond. However little research exists about what family members experienced in terms of contact and support from mental health services providing care for their relative.

Using a semi-structured approach I interviewed family members about their experiences following a relative's suicide; particularly their experiences of contact and support with mental health services. Staff members were interviewed separately about their experience of making contact with and offering support to the bereaved families. The data was analysed using grounded theory, with a strong emphasis on researcher reflexivity. The findings revealed that family members felt excluded by staff from their relatives' care before and after death, despite guidance and policy recommending that organisations work in partnership with the families of people in their care.

The mental health staff I interviewed reported feeling poorly prepared for making contact with families, breaking bad news and providing support. Whilst policy and guidelines exist about how to support staff when an event like suicide occurs, it appears these are inconsistently applied and do not take account of the varying needs of staff at different levels, including management.

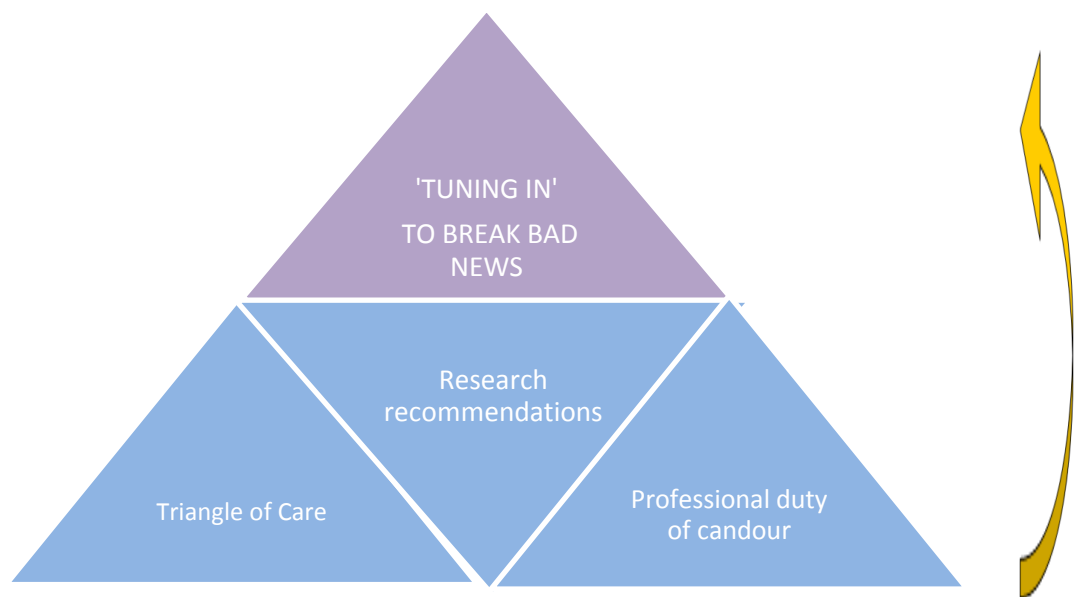
What became apparent through the course of this study was the dominance and constraints of NHS policy, and the pressure to change at great speed in order to keep pace with quantitative evidence-based research about what works. The structure and systems within the NHS resemble what can be understood by applying general systems theory (von Bertalanffy, 1950), as it operates through regulation and governance via linear processes and feedback loops. However, this has left a gap in terms of information and evidence from service users, carers and their families and staff. This research attempts to fill that gap.

Using the method and design of this study yielded rich first-hand evidence which defied strict categories of meaning. The grounded theory social constructionist stance enabled data to be analysed and placed within a conceptual skeleton (Charmaz, 2006), which set parallels with the NHS's structure; however this inevitably resulted in the exclusion of some voices. Within the conceptual skeleton I posed a question about the location of the heart, which can signify many things, for example the centre which pumps blood to the rest of the system, and in this case for me speaks of the compassion and appreciation of human experience. Indeed I am tempted to ask the same question of the NHS. This research concludes that more study is needed in the area of suicide support and sets out recommendations which might aid training and improve contacts with service users.

The importance of seeing suicide in context as well as within the medical discourse has been a thread I have been keen to weave throughout this study. As a systemic practitioner I am not only thinking about staff working in organisations, but also of the increased scope and opportunity to understand the act of suicide, to consider a person's psychosocial context as opposed to the narrow definitions and understandings that the mental illness paradigm offers. I have been struck by the similarities between how structures, processes and labelling serve to constrain something un-constrainable. I struggled immensely against the overwhelming temptation to sanitise and organise the whole endeavour. However this does present parallels to what happens when a suicide takes place, because suicide is messy, complicated and on some levels unbearable to think about, which induces the desire to clean it up, close it down and put it away.

My final illustration, Figure 55, follows the style of the previous research pyramid (Figure 7). It incorporates and blends research recommendations and systemic influences with the Triangle of Care (Carers' Trust, 2010; 2013), the Professional Duty of Candour (GMC, 2015; NMC 2015) presenting similarities to a 'braided challah' (Hoffman, 2000). This model brings together my hope to enable staff to 'tune in to breaking bad news' and therefore could provide a possible solution to the difficulties in suicide support that this research has revealed.

Figure 55 Pyramid of recommendations



This final figure brings this research to a conclusion and offers a tripartite way of conceptualising ideas about how to improve the experience of the relationship between families and staff after suicide. The quotes I used at the beginning of this study led me to wonder whether at some point the bringing together and sharing of these experiences might be possible. Families seek help and treatment from services for their problems, and staff go to work in these services to provide just that. So there needs to be motivation within services to adapt their methods of working, to create space for the things that really matter, build on care and compassion as highlighted by this study, which in turn will influence improved experiences in a heartfelt way for all involved in the tragic business of suicide.

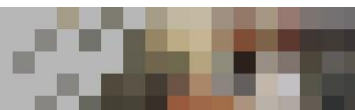
The findings and conclusions from this research will be presented to the mental health organisation within which the study took place, and will hopefully feed

into guidelines about how to support families/carers following the suicide of a person receiving care. Furthermore, recommendations are suggested about how and when to support and provide assistance to staff members. Findings in an abbreviated form will be provided to the research participants, members of the carers' participation groups, staff and others who have kindly contributed to this study.

Appendix 1. Research Protocol



THE GRADUATE SCHOOL



APPLICATION TO REGISTER FOR A RESEARCH DEGREE PROGRAMME

(TO BE COMPLETED BY THE PROPOSED SUPERVISORY TEAM AND THE STUDENT)

In completing this form you should refer to the relevant sections of the Research Degree Regulations (Part 9 of the UEL Manual of General Regulations) and the UEL Code of Practice for Postgraduate Research Programmes.

This form should be typewritten wherever possible.

Confirmation of registration will be sent to the student's and the Director of Studies' UEL email address.

When fully completed, this form must be submitted to the nominated individual in the School - usually the Research Administrator or Officer to the RDSC, accompanied by Form SDN for each supervisor nominated.

1.

IF YOU HAVE MADE ANY PUBLICATIONS THAT YOU FEEL SUPPORT THIS FORM, PLEASE GIVE REFERENCES.	Bird, G. 2009. The influences of suicide upon the professional, a research study. <i>Context</i> 101 p31-32.
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2. THE PROGRAMME OF RESEARCH

PROPOSED TITLE OF THESIS	Research into the experience of the relationship between family/carer and staff from the mental health services after suicide. What are the implications for the mental health services?
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Please include in your discussion a description of the research methodologies and explain why these methodologies are the most appropriate for the task. Include a list of references for all works cited.

Section 1. Setting the scene.

Families and carers.

It is relatively recent that the needs of families and carers have been acknowledged formally (DH 2002 a). This is reflected on a national level where it has been increasingly recognised that families and carers of people with mental health problems have often felt unheard and excluded from their relatives care. Research exploring the needs of families and carers has concluded, "They would like to be listened to, supported and to be involved with planning a relatives care... information is required about diagnosis, treatment, services, benefits and whom to contact in an emergency...however a cultural shift in mental health services is required if partnership working is to become a reality" (Stanbridge and Burbach 2004, 2007).

This is relevant for families and carers consisting of a member with a wide variety of conditions, including mental health problems. When a person dies through suicide, whilst receiving mental healthcare, partnership working with a family or carer of that person is even more important. In the report on the 'National service framework for mental health: five years on' (DH 2004) the needs of carers was clearly acknowledged which is reinforced in 'The Triangle of Care; carers included: A guide to best practice in acute mental health care' (National Mental Health Development Unit 2010).

Suicide prevention, National policy and guidance.

Suicide prevention is a key national priority for the public health and mental health services (D H 2002 b, 2009). People with mental health problems are a particularly high risk group and it is vital that mental health services improve clinical practice if suicide is to be prevented (The National Patient Safety Agency, NPSA 2009). Findings reflect reduction of inpatient suicides (Appleby et al 2006), nonetheless a family history of suicide has been shown to be associated with suicidality at all stages of the life cycle (Roy et al 2000). Within *Preventing Suicide: A toolkit for mental health services* (NPSA 2009 p16) standard 7, Post incident Review relates directly to the impact a patient suicide may have upon staff, patients, carers and families. This sets out an audit procedure to conduct serious untoward incident reviews and support of staff, family/carers and relevant others involved or affected. Furthermore this recommends that a multi disciplinary team review is carried out within two

weeks and that all staff, patients, family/carers affected by a suicide are given prompt and open information with the opportunity to receive appropriate and effective support as soon as they require it.

In addition standard 4 of the Toolkit (NPSA 2009) specifically targets family/carers by inquiring whether they were notified of a serious untoward event (including suicide) by the mental health service in a timely way, whether an identified person was designated with whom to communicate and whether the family/carer were invited to participate in the serious untoward event review and gain sight of the report and recommendation/lessons learnt (NPSA 2005, 2009).

With audit mechanisms to measure activity locally and nationally statistics about patient suicide are rigorously collected. Good practice guidance sets out basic principles that underpin communication between the National Health Service and patients/carers when an incident of serious harm or death occurs. This includes; the principle of acknowledgement, truthfulness and apology, “with any contact to be undertaken in a respectful, dignified and compassionate manner and in a spirit of openness” (NPSA 2005, p19).

Families / carers, staff members and the impact of suicide.

Bereavement through suicide is not uncommon. There are approximately 5,500 deaths by suicide each year in the United Kingdom and it is suggested that on average 6 people are deeply affected by each one, which amounts to at least 30,000 bereaved individuals per year and six million worldwide (Clark and Goldney 2000). This estimate of numbers affected are conservative and does not include those outside of the immediate family, like colleagues, or members of the caring professions (Hawton et al 2008).

Suicide and trauma are often linked. The National Institute for Clinical Excellence (NICE) recommend watchful waiting for people that have been exposed to trauma (NICE 2005). However grief is a natural part of being human. A variety of language is used to describe the process of grief. Words including ‘resolved’, ‘worked through’, ‘moving on’, ‘closure’, ‘coming to terms with’, ‘reconciled’ and so on. As McGoldrick et al (1992) urge, by adopting a culturally sensitive way that eschews widespread generalisations about mourning and assumptions about the “need to get it out” interventions need to

intend to respect individual family members ways of dealing with the aftermath of tragedy.

Working with families and carers. Local policy and guidance.

The Somerset Partnership NHS Foundation Trust adopted a strategy to enhance working partnerships with carers and families in 2002. This strategy includes the following vision:

“The Somerset Partnership Trust will strive to respond to the needs of carers and families in all parts of the service. This entails having a social network perspective to all assessments and interventions provided by our staff and the involvement of families and carers in service delivery where ever possible.”

Working with families and carers of persons receiving care and treatment is generally well established, however what happens when a person ends their life by suicide, whilst receiving care from the mental health service is less clear.

Literature review.

The main areas of literature relevant to the study are concerning support of families/carers after the suicide of a family member receiving care from the mental health services and the impact upon staff members.

The impact of suicide upon families and carers.

Sometimes referred to as ‘survivors of bereavement by suicide’, following the suicide of a family member, people may experience more disturbed family dynamics and psychiatric illness, higher rates of adult and child loss and most significantly lack of support in bereavement (Clark and Goldney 2000). In spite of evidence that bereaved individuals need significant support and are at risk of increased morbidity (Mitchell et al 2005) and even suicide themselves (Qin et al 2002), people in personal or professional roles may not know how best to deal with the grief of those bereaved.

‘Help is at hand for people bereaved by suicide and other traumatic death’ (Hawton et al 2008) describes the complicated issues involved in supporting those who are bereaved, which includes advice for friends, employers, police,

health and social care personnel. The increase in attention to supporting people bereaved by suicide is further borne out within the report of the first international Suicide Postvention Seminar '*Current understandings of suicide survivor issues: research, practice and plans:*' (Andriessen, et al. 2007) which looks into the goals of the postvention taskforce of the International Association for Suicide Prevention (IASP).

More recently Andriessen (2009) reviewed postvention support indicating this can contribute towards suicide prevention among those bereaved by suicide and recommends further development of support programmes. A systematic review of eight studies of interventions for people bereaved by suicide revealed the effectiveness of family intervention and group therapy for children and adults, whilst also highlighting the need for Randomised Control Trials into efficacy (Mc Daid et al 2008). Indeed research focusing on qualitative aspects that differentiate suicide bereavement from other bereavement, also addressing stigma surrounding the act of suicide (Jordan 2008) might ensure that those most affected are better protected from the fallout that accompanies such a traumatic event (Flynn and Robinson 2008).

Wheeler (2009) suggests adopting a solution focussed stance when working with the bereaved, as without giving people the opportunity to name the outcome they expect to achieve, there would be a danger of influencing conversation with ones own views. For example, about whether there is an afterlife. Whether or not it is possible to sustain a relationship with someone after they have died and how should one carry on living. Similarly Colmer and Suresh (2009) state having worked with a family following the suicide of the eldest son they created a climate that fostered empathy and tolerance of different reactions in the family.

However when suicide occurs during an episode of care and treatment it presents profound ethical, legal and spiritual challenges, dilemmas and questions, individually and as a community. There are perhaps unanswerable questions that need to be brought into discussion, about 'why' and 'what if' (Rycroft 2004 p 253). There are some tragedies and human suffering that cannot be 'therapised away' and whilst it is really important to promote what can be done in people's lives to help make a difference, it is also important to

recognise and share experiences of our limitations. Hoffman (1992) asserts overwhelming grief at the death of a loved one is a natural human process that does not necessarily need therapy or expert input that might 'professionalise', indeed even 'pathologise', normal grief reactions. Hence keeping an open mind, being aware of the pull to "rescue" and giving careful thought to the best timing for responding to requests for professional involvement in the context of bereavement after suicide is essential (Shachar 2010).

The impact of suicide upon mental health staff members .

The following summary briefly outlines literature into research of the impact of suicide upon professionals.

The effects on a professional when a patient ends their life through suicide cover a wide spectrum including feelings of loss, shock, denial, anger and failure to name but a few. There is no classic response to such an event. For example, the professional that discovers the dead person, touches the body and attempts resuscitation, may be left with longstanding sensory images (Joyce and Wallbridge 2003). Hendin et al (2000; 2004) found that one third of professional's experienced severe distress when a patient ended their life through suicide which continued for a year in some cases, with a lessening two years afterwards

Little (1992) outlines three overlapping phases that professionals might go through following the suicide of a patient: initially a sense of loss of control, shock, stunned disbelief, distractibility, disorientation and bewilderment which lasts several days. This is followed by a period of about two months when there may be overwhelming emotions and feelings of anger, guilt and depression. Finally over the next two to four months the intensity lessens and the opportunity for personal and professional growth or prolonged disability arises.

The way this might manifest varies from person to person, however guilt may be expressed through blaming, self-doubt or inefficient under productive overworking. Individuals may withdraw from working either physically or psychologically which might result in sickness, absenteeism (Feldman 1987) or taking another job (Cotton et al 1983). Social isolation may occur, self-

confidence and self-esteem at work may diminish and this might impact onto other areas of life including family relationships and home life (Alexander et al 2000). Factors that may affect the impact upon the professional include whether the individual feels blamed by the family, colleagues or the organisation and the potential threat of a lawsuit (Hendin et al 2004). Indeed individual factors for example; age; level of experience and gender (Grad et al 1997, Kovac and Range 2000) might affect a professional's vulnerability to severe distress.

Literature summary.

Extensive research has been conducted into the impact of suicide and the effects upon the people around the person, including family/carer, staff members, etc. There is strong evidence that the impact is huge and may depend to an extent upon variables including individual factors, nature of the relationship, circumstances and mode of death, etc.

It is important to consider this literature, as it may in some part inform professionals, in the process of communicating with and imparting information to the family when something goes wrong. Indeed dealing with one's own grief when the patient has died and talking to the family of the deceased is acknowledged to be extremely challenging (Bird 2009). Breaking bad news is never easy. It is made more difficult by the unique relationship that is involved between patient and family, the subject of 'bad news' and the person imparting it. Irrespective of the preparation and education that might be given in this area, breaking bad news is rarely a neat and tidy experience (Hart 2006).

National policy and research outline recommendations and guidance about what organisations need to do in the event of a patient suicide. However one might ask whether such guidance is followed and what aim this might have. Clearly collection of statistics informs about the incidence of patient suicide. If guidance is followed, does it function as a mechanism to assure regulatory bodies that healthcare provided was of a good standard. Or is the aim of following guidance to genuinely learn from the people most directly affected by the experience to work towards improvement in the future.

Section 2. Rationale and Research Question.

My position as a researcher of this topic.

The effect upon people of a patient suicide has been a constant theme throughout my career in the National Health Service. Within my professional capacity I have first hand knowledge and experience of talking to families about the death of their relative that spans many years. I do not recall any training to assist me with this process, more a sense of “feeling your way”. As part of my current job I conduct serious unexpected event reviews into incidents including the death of a patient. In addition I convene post incident staff support meetings following the death of a patient.

This work is challenging and difficult at times. Taking account of and acknowledging people’s emotions and responses in highly stressful situations is complex. However this is similar to what presents at times in the therapeutic work of systemic family therapists and this is the theory base that usually assists me through this process. This does not mean I will necessarily have answers. It does mean that I am interested in listening and discovering with people what it is like to go through this experience first hand, for example; the emotions they might feel, for the family the way they feel they were treated by the service, and for the staff what it was like to deliver ‘bad news’ and what that might entail.

When considering the rationale and research question for a study Finlay (2002) urges, it is imperative to examine ones own motivations as a way of understanding others and as such the kind of knowledge the researcher might be laying claim to (Charmaz 2006). Therefore as preparation for this work it has been important to carefully consider my position on suicide, from different perspectives whilst also attempting to be curious and remain open to what is unexpected, essentially not allowing what I think I know to get in the way of this study. As part of the preparation for this research, consultation with carers and families groups within the mental health service was undertaken. I met with and spoke to two groups and there was general support that this was a worthy area to research, however carers of service users particularly found the subject of suicide very difficult to think too deeply about, preferring to put their energy into caring for the person instead.

As mentioned earlier statistics are collected about the suicide of a patient, in terms of demographic data, method, etc. Literature tells us of the suffering for

family/carers connected with the person and that people bereaved from suicide stand an increased likelihood of complicated bereavement and the possibility of developing mental health problems themselves. The literature also highlights the impact of patient suicide upon staff members, with national and local policy guiding what organisations need to do after the death of a patient. However little information of a qualitative nature appears to exist about what help family/carers would like from the mental health service when the suicide of a relative occurs whilst receiving care, or indeed what the staff working in the mental health service need to help and support them with this highly sensitive process.

Therefore having reviewed the research literature, national guidance and taking into account my individual work experience and knowledge, I wish to try to address this gap by listening to people most closely affected and discovering more about what help people received (or gave) at the time that their relative died and how well these processes went.

In this qualitative research proposal I am posing the question: -

***“Research into the experience of the relationship between family/carer and staff from the mental health service after suicide
what are the implications for the mental health service?”***

I propose to do the following:

- a) Gather information from family/carers by face-to-face interviews about their experience of how they were informed and what support they received after a relative in the care of the mental health service ended their life through suicide. I will be asking about what contact, information and help was offered and whether the intervention was experienced as helpful or unhelpful. I will also ask about what family/carers might have expected or wanted from the mental health services at the time or afterwards.
- b) Gather information from a selection of staff from the mental health service, using face to face interviews to ask them what it was like to inform the family of the death of their relative, what support they offered to the family/carer, how they knew what to offer and how this was received.

My overall aim to equip staff to undertake this process more effectively and

ultimately improve what is offered to families and carers by the mental health service following such an event in the future.

Section 3. Method.

Research design.

As this study is aimed at studying social processes “from the bottom up” this study will be a qualitative naturalistic design, using semi structured interviews to elicit from families/carers and staff their accounts of their experience of contact following a suicide in the mental health service. I am curious to trace patterns of social interaction that have combined to give rise to particular identifiable social processes (Willig 2000 p47) and the meaning the participants attach to their social world (Charmaz 2006).

Selecting participants for the study.

Selection of the research participants will begin by obtaining the confidential list of all cases being cared for by the mental health service where a suicide has occurred in the 12 months before the start of the study. The total number of suicides, as determined by HM Coroner known to the local mental health service equates to approximately 15 per year. Exclusions would include those families/carers that are seeking legal recourse or who are known by the researcher.

With the appropriate permission from the mental health service a letter will be sent which has been sensitively worded explaining the aim of the study and enquiring whether they would be willing to be interviewed by the researcher about the way they were informed about the death of their relative and the support and information they received from the organisation. Similarly a letter would be sent to a small sample of staff from the mental health service involved in informing the family/carer of the death of their relative, explaining the aim of the study and whether they would be prepared to be interviewed by the researcher. Relatives would not be asked to identify the staff member, if any, with whom they had contact. Nor will staff be asked to identify any families they have been in touch with. Therefore for the sake of anonymity, the families and staff will not be ‘paired’.

The aim will be to obtain a sample of self-selecting participants that might be prepared to undertake a face-to-face interview with the researcher.

Consequently the sample will be purposive as it deliberately constitutes non-random sampling aimed at a group of people with a particular characteristic (Bowling 1997). By this means, it is anticipated that a minimum number for face-to-face interviews for both groups would be five participants, with the maximum being between eight or ten. If volunteer numbers exceed these figures, the aim would be to undertake an interview nonetheless as it would be unethical to invite people to volunteer and then decline to interview them. If the number falls below expected minimum then the names from the previous year will be approached. Indeed, in keeping with grounded theory, information might be obtained from other sources, for example carers support workers employed by the mental health service, as according to the theoretical needs of the research and as data analysis progresses (Field and Morse 1996).

Data collection.

I am planning to carry out this research with two different participant groups, family/carers and staff. Semi structured face-to-face interviews will be used to gather information for the study. It is anticipated that I will be able to glean accounts that are conceptually rich, dense and contextually grounded, in keeping with the goal of grounded theory, (Pidgeon 1996 p78).

In using grounded theory the research question will be somewhat open ended because the process is facilitated by theoretical sampling and theory sensitivity, so that by the time theoretical saturation is achieved the research question may have evolved (Willig 2008).

Semi structured interviews.

Having obtained consent and permission, the participants will be invited to meet with the researcher by letter or telephone to be interviewed face to face. The semi structured interviews will be conducted using the interview schedule, (Appendix 1 and 2) and will be undertaken separately with the family/ carer and staff member. In the case of the family this could be in his or her own home or another location of their choice, for example NHS premises that will afford a good level of anonymity and confidentiality. The family/carers may wish to have someone with them, for which consent will also be discussed and agreed. For members of staff the interview will take place in NHS premises, with appropriate safeguards to maintain confidentiality and anonymity. It is anticipated the interview will last between 60-90 minutes and will be audio

taped. Care will be taken to pose the questions sensitively and allow plenty of time for the participants to answer. If at any time the individual/family wish to discontinue the interview this will be respected. Transcription of the data will commence after the interview. This will be forwarded to the participant to read, check and amend.

Method of analysis.

Grounded Theory.

Grounded theory originally developed by Glaser and Strauss (1967) will be used for data collection and analysis resulting from the study. The theoretical base for grounded theory is symbolic interactionism, which stresses that human behaviour is developed through interaction with others, through continuous process of negotiation and renegotiation (Morse and Field 1996). The theory suggests that people construct their own reality from symbols around them through interaction, rather than static reaction to symbols. Therefore individuals are active participants in creating meaning in a situation and the purpose of grounded theory is to generate explanatory theory around human behaviour.

Grounded theory involves the progressive identification and integration of categories of meaning from data collected through, in this case, face to face interviews. Grounded theory is both the process of category identification and integration, as a method offering guidelines on how to identify categories, how to make links between categories and how to establish relationships between them. Grounded theory is also the end product of this process by providing an explanatory framework with which to understand the phenomena under investigation.

For this reason it appears to present the optimal method and theory for the study, in that it does not provide a set of steps which will lead from the research question through to the production of a research report. Grounded theory instead allows for the researcher to continuously review earlier stages of the process and if necessary change direction. By working with induction, this may mean insufficient attention is paid to the role of the researcher and the process becomes nothing more than a technique for systematic categorisation (Willig 2008). However Charmaz (1995) addresses such

concerns and suggests reflexive grounded theory by developing a social constructionist version.

This method provides an ideal opportunity to build in aspects of researcher reflexivity, as part of the inductive nature assumes an openness and flexibility of the approach by following leads gained from analysis of the data, not from careful, exhaustive literature review. Hence simultaneous involvement in data collection and analysis means the researchers emerging analysis shapes the data collection, thus permitting the pursuit of topics that are explicit in one interview or observation and remain implicit or absent in others (Charmaz 1995).

For example within some interviews there may be the opportunity to gently explore what it means to have experienced a suicide in the family and how this becomes integrated into the history of the family. This presents similarities to systemic practice by considering with the family beliefs, culture, actions and so on. Indeed this kind of reflexive research has appeal for clinicians because it mirrors to some extent the reflexivity inherent in good clinical work by requiring the researcher to consider the impact of their own professional and personal backgrounds, a range of theoretical social and cultural assumptions, their understanding of clients, etc. (Wren 2004).

It is reasonable to expect that issues around grief and bereavement will be present in some way, at least for the relatives of the deceased. Bereavement theory will therefore guide me to be prepared to listen and acknowledge strong feelings such as anger, blame, guilt, regret and disappointment, etc.

Acknowledgement of participants voice and their views about the death of the person will form a fundamental part of the research. "Acknowledgement is an explicit expression of something already known (by the speaker at least) which is communicated to another person.... it usually occurs as a process of articulation through which some particular knowledge is brought into clear awareness, to stand out in sharp relief, to be attended and responded to" (Tomm and Govier 2007). As Finlay (2002) suggests reflexivity in qualitative research involves the engagement of the researcher in explicit self-aware meta analysis. In doing so the researcher tries to make explicit how intersubjective elements impact upon data collection and analysis as an effort

to enhance trustworthiness, transparency and accountability of their research. As this is part and parcel of the principles of grounded theory in my view grounded theory presents a good fit to the subject of study.

Ethical considerations.

As Lakeman and Fitzgerald (2009) point out when conducting suicide research, in addition to being sure that the potential benefit from the research is great enough to warrant intrusion on a vulnerable population, the researcher need to be experienced in working with suicidal people. Confidentiality, anonymity and trust are basic qualities that are crucial to any study, however in the area of a sensitive subject like suicide, even more so.

Therefore anonymity and confidentiality will be explicitly built into the consent form. Also assurance that, should the potential participants volunteer or not, they will not be discriminated against should they require the mental health services. Indeed If at any time participants wish to discontinue with the research, this will be respected.

In order to undertake the research collaboration and transparency will be required with and between both the organisation and participants. It is important to note that staff members may be open to criticism and legal proceedings by aggrieved family/carers. We are told we are to working towards a 'no blame culture' the reality is we are working in a blame culture which can be exacerbated by hasty actions after a high profile suicide (Sireling 2004). Nonetheless by providing the opportunities for non-judgemental questioning, reflection and disclosure, honest feedback is helpful to the bereaved family/carers and staff. Through the process of this research this may be possible, akin to helping the unsaid become spoken, which may provide some clarity (Rober 2002).

Staff members who participate might too be grieving the loss of the person; hence strong feelings may be present. There maybe a danger that the staff perceive the study to be in some way checking on the standard of care delivered. To obtain a willingness to participate, it will be important to clarify and separate the research from the organisational processes of the serious untoward event review into the death.

During the research participants may experience distress or become upset. It

is appropriate to anticipate this possibility due to the subject content. As a clinician it may be possible to see this coming and in some way “head it off”. However it may also pose the opportunity to establish a route to accessing help in the family or individuals own right for services. Nonetheless, the facility for participants to speak to a colleague of the researcher employed by the mental health services, if the need arises, is an aspect that has been accounted for. Ethical approval will be sought from the South West Strategic Health Authority ethics board once the UEL/Trust examination board has approved this proposal.

Conclusions.

This qualitative study is researching the experience of the relationship between the family/carers and staff from the mental health service after suicide. Data will be collected through face to face semi structured interviews with participants, both family/carers and staff. Following analysis of the transcribed data through Grounded Theory the findings of the study will be presented to the mental health service to feed into guidelines for family/carers support provided after the suicide of a patient whilst receiving care. Guidelines may also be developed for assisting staff members involved in the process of informing family/carers about the death of their relative, and offering support from the mental health service. In addition, findings in an abbreviated form will be presented to research participants, members of the carers participation workers group, staff and others who have contributed in the study.



National Research Ethics Service

NRES Committee South West - Southmead

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23 August 2011

Ms Gina Bird
Consultant Nurse Liaison Psychiatry/Family Therapist
Somerset Partnership NHS Foundation Trust
Holly Court Summerlands
56 Preston Road
Yeovil Somerset
BA20 2BX

Dear Ms Bird

Study title: "Research into the experience of the relationship between family/carer and staff from the mental health service after suicide".what are the implications for the mental health service?
REC reference: 11/SW/0081

Thank you for your letter of 01 August 2011, responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information was considered in correspondence by a sub-committee of the REC. A list of the sub-committee members is attached.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised, subject to the conditions specified below.

Ethical review of research sites

NHS sites

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

Non-NHS sites

Conditions of the favourable opinion

The favourable opinion is subject to the following conditions being met prior to the start of the study.

This Research Ethics Committee is an advisory committee to the South West Strategic Health Authority
The National Research Ethics Service (NRES) represents the NRES Directorate within
the National Patient Safety Agency and Research Ethics Committees in England

Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned.

Management permission ("R&D approval") should be sought from all NHS organisations involved in the study in accordance with NHS research governance arrangements.

Guidance on applying for NHS permission for research is available in the Integrated Research Application System or at <http://www.rdforum.nhs.uk>.

Where a NHS organisation's role in the study is limited to identifying and referring potential participants to research sites ("participant identification centre"), guidance should be sought from the R&D office on the information it requires to give permission for this activity.

For non-NHS sites, site management permission should be obtained in accordance with the procedures of the relevant host organisation.

Sponsors are not required to notify the Committee of approvals from host organisations

It is the responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

<i>Document</i>	<i>Version</i>	<i>Date</i>
Covering Letter		05 April 2011
Covering Letter		01 August 2011
Investigator CV		25 March 2011
Other: Invitation Letter - Staff - Appendix 1	2.0	21 March 2011
Other: Invitation Letter - Family/Carer - Appendix 2	2.0	21 March 2011
Other: Interview Guide - Staff - Appendix 5	6	23 March 2011
Other: Interview Guide - Family/Carer - Appendix 6	4	23 March 2011
Other: Letter of invitation (staff member)	III	01 August 2011
Other: Letter of invitation (family member/carers)	III	01 August 2011
Other: Research reply slip	1	01 August 2011
Other: M10 Assessment Board letters		11 July 2011
Participant Consent Form	1.0	23 March 2011
Participant Consent Form	2	05 August 2011
Participant Information Sheet: Staff - Appendix 3	3.0	23 March 2011
Participant Information Sheet: Family/Carer - Appendix 4	3.0	23 March 2011
Participant Information Sheet: staff member	4	01 August 2011
Participant Information Sheet: family/carers	4	01 August 2011
Protocol	1.0	
REC application		25 March 2011
Response to Request for Further Information		01 August 2011

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating

Procedures for Research Ethics Committees in the UK.

After ethical review

Reporting requirements

The attached document "*After ethical review – guidance for researchers*" gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators
- Notification of serious breaches of the protocol
- Progress and safety reports
- Notifying the end of the study

The NRES website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

Feedback

You are invited to give your view of the service that you have received from the National Research Ethics Service and the application procedure. If you wish to make your views known please use the feedback form available on the website.

Further information is available at National Research Ethics Service website > After Review

11/SW/0081

Please quote this number on all correspondence

With the Committee's best wishes for the success of this project

Yours sincerely



Dr Pamela Cairns
Chair

or

Enclosures:

List of names and professions of members who were present at the meeting and those who submitted written comments

"After ethical review – guidance for researchers" (via Email)

Copy to:

Ms Hannah Hewitt, Somerset Partnership NHS Foundation Trust



NRES Committee South West - Southmead

Attendance at Sub-Committee of the REC meeting on 12 August 2011

Committee Members:

Name	Profession	Present	Notes
Dr Pamela Cairns	Consultant Neonatologist	Yes	
Dr Margrid Schindler	Consultant Senior Lecturer	Yes	

Also in attendance:

Name	Position (or reason for attending)
Ms Mindy Kaur	Assistant REC Coordinator
Mrs Naazneen Nathoo	REC Coordinator

Appendix 2. Interview guide [staff]

Please see participants' information sheet and consent.

Examples of Interview themes:

- Firstly can I ask you about your role in this area of work, how long you have worked here, what brought you into this field?
- It's never easy when someone dies in this way; is this something that you have been involved with before?
- Are you able to tell me what this was like, perhaps generally and more specifically about a recent case?
- What was your relationship like with the client and their family?
- How was it decided that you would contact the family?
- Can you tell me something about how you felt when notifying the family/carer about the death?
- In what way was the family/carer informed about the death of their relative? (*phone call, face to face*)
- Did you have previous contact with the family/carer? When you spoke to the family how did the conversation go?
- What do you recall about what you said to the family/carer at the time, i.e. what do you feel was positive/supportive, and what you would have liked to have happened?
- What did you say to the family about whom to make contact with afterwards if they needed information or support? Was an opportunity to meet with the family offered? (This may have been with someone else from the mental health trust)?
- Additional information (if not already included).
 - Have you had to make relatives aware of a death before?
 - How did you know what to do, what to say/offer?
 - How do you think the family received this?
 - Did you receive any support with doing this?

- At the time or afterwards?
- What ideas do you have about if this goes better/worse?
- Are there ways of saying it differently?
- In what ways could it have been done differently?
- Are there any questions that you hoped I would ask you?
- Is there anything else you would like to say?

Thank you.

Appendix 3. Staff letter 1

Dear [Staff member]
invitation (staff)

Letter of

I am writing to invite you to consider participating in a Doctoral research study. The research project is called;

“Research into the experience of the relationship between family/carers and staff members from the mental health service after suicide; what are the implications for the mental health service?”

To gather information to address this question, staff members who have cared for a client being cared for by the Somerset Partnership, who ended their life by suicide, are being invited to participate in a face to face interview which aims to listen to you talk about issues including:-

- what happened when a client ended their life through suicide, and
- what it was like as staff member caring for the deceased person at the time, afterwards and what support was offered to you?
- What was it like to contact and discuss with the family/carers of the client about what had happened?

It is important to acknowledge this is a potentially sensitive subject however this seems a very important area to try to learn more about. By listening to the views of staff members it is anticipated that this research will improve understanding of what happens currently within the Somerset Partnership when a death occurs in these circumstances. In particular information about how staff managed and felt at the time, feel now and what might have been helpful to them, may be used to develop improved guidance within the organisation when staff are providing support to families/carers bereaved by suicide.

Staff members from across the organisation are being invited to participate in this research.

Family members/carers whose relative has ended their life through suicide whilst receiving care from the Somerset Partnership in the last two years are being invited to participate in a separate part of this study.

If you feel you would be willing to be interviewed about this subject, I would appreciate it if you would fill in the reply slip and return to the researcher directly within the next two weeks by using the enclosed stamped addressed envelope. However completing the slip does not mean that you have to take part if you change your mind. Thank you for taking the time to read this letter.

Yours sincerely,

DR CHRISTOPHER MORTIMORE

Medical Director

Appendix 4. Staff Letter 2

Invitation letter (Staff) (Amended)

Dear [staff member]

As part of a professional Doctorate with the Tavistock and Portman NHS Foundation Trust and the University of the East London, I am undertaking a piece of research called;

“Research into the experience of the relationship between family/carer and staff members from the mental health service after suicide; what are the implications for the mental health service?”

To gather information to address this question, I am hoping to interview a number of staff members of The Somerset Partnership NHS Foundation Trust, about

- what happened when a patient known to them ended their life through suicide, and
- what it was like to be involved with the family/carer of the deceased person at the time and afterwards.

In a separate part of this research I am hoping to interview family members/carers.

I acknowledge this is a potentially sensitive subject. However having been involved in working with clients and families effected by suicide throughout my career in the NHS, this seems a very important area to learn more about. It is anticipated that this research will improve understanding of what happens currently, and how staff members manage and how they feel when faced with this often quite difficult process. The findings will be used to develop better guidance and support to staff within the organization when supporting families/carers bereaved by suicide.

The Somerset Partnership NHS Foundation Trust hold a confidential list of unexpected patient deaths, which includes suicide. Staff members who have been involved in the care of a patient who ended their life through suicide in the last two years are being invited to participate in this study.

I am therefore approaching you to ask if you would be prepared to participate in this research study. If you feel you would be willing to be interviewed by me about this subject, I would appreciate it if you would contact me by letter, e mail or phone, as above, within the next two weeks.

If you are already participating in a research study, it would inappropriate for you to participate. Thank you for taking the time to read this letter.

Yours sincerely,

Gina Bird

Appendix 5. Staff Member Information Sheet

Project Title:

“Research into the experience of the relationship between family/carer and staff from the mental health service after suicide”. What are the implications for the mental health services?

When someone dies unexpectedly many mixed emotions arise and impact upon the family/ carer of the deceased and also the staff delivering care. This is an area that, possibly because of the sensitive nature, has not been researched a great deal. However such tragic events do happen therefore the way the mental health service staff communicate, inform and support the deceased persons family/carer is of utmost importance and worthy of investigation.

We are very keen to ensure we develop and improve ways we relate to family members that experience a death in the adult mental health service. To attempt to address this, I am interested in finding out about the experience of the relationship between family/carers and the staff from the mental health service after the unexpected death of their relative. If people are prepared to join this study, the way I aim to do this is to talk with a number of family members/carers of the deceased person about what it was like and how they were supported by staff from the mental health service at the time and afterwards.

In addition I will endeavour to separately talk with a number of staff members from the adult mental health service about their experience of being involved with supporting the family/carer after the death of their relative. By this method I hope to gather information from both perspectives, which would after analysis, assist in developing guidelines for staff of the mental health service about how to support families/carers going through loss and bereavement of their relative in this way. Indeed I hope that this research will help staff to understand more about helpful and unhelpful ways of responding to families/carers so that they can provide the best possible service.

It is very hard when something like this happens, for the family members and the staff involved. If you agree to take part in this project you need to be aware that I am sorry this has happened however I will have not been involved in any way with the care/treatment of your relative before their death.

It is anticipated that the interview will take between 60-90 minutes. If you consent, this will be audio recorded. Please see consent form.

I have some questions to help me to structure the interview and I would also like to ask you about things that seem relevant that come up as we are talking. This subject is very sensitive and I will endeavour to bear this mind throughout our meeting. It is important that you feel confident to tell me if you would rather not answer a particular question I ask you and that you would feel comfortable to say if you would like the interview to stop at any time. At the end of the interview I will provide some information about sources of support for people who are bereaved. I hope you find this is useful.

You are free to withdraw from the research at any time.

The rules of confidentiality will apply to you. Audio tapes of our discussion will be encrypted for additional security and kept in a locked cabinet. When the audio tape is transcribed, all names and anything that might identify you will be changed to ensure anonymity. The interview will be forwarded to you to check the contents and you may alter or change things you wish to before returning to me. At this point analysis of the information will begin.

At the end of the study audio recordings and transcripts will be destroyed. I will use extracts from the interviews however this information will not be identifiable. I will endeavour to publish the results of the research in a doctoral thesis and possibly elsewhere, for example a professional journal. I will ensure that you will not be identifiable in any published material.

Appendix 6. Interview guide. [Family members]

Please see participant's information sheet and consent. Examples of Interview themes:

- Can I begin by asking you how you refer to your [relative] what do you call him/her and how would you like me to refer to him/her?
- To enable us to ask about this, are you able to tell me how you refer to the death of your relative, the words you use [suicide, took own life, passed away etc].
- Tell me about your relative [name]. What was he/she like?
- To help me understand a bit about your family can you tell me who is in your family? Brothers/sisters, aunt, uncle, etc.
- What did you know about your [relatives name] condition and the care he/she was receiving? How much did he/she [name] tell you about their problems?
- How much were you involved? Did he/she [name] let you become involved?
- How would you describe your relationship with the staff? Examples, i.e. had you met the staff involved in his/her [name] care?
- [If admitted to a ward] Did you attend a family liaison meeting?
- How did you find out about the death [own term] of your relative [name]? In what way were you made aware? What was this like?
- Whilst we cannot change what has taken place, you may have thoughts about what you feel could have been done differently. Can you tell me about this?

Additional information (if not already included).

- Did you already know the person /member of staff who made contact with you? Did they provide their name?
- Do you recall what was said to you at the time?

- What was said to you about whom to contact for information and support if you needed it?
- When you were contacted did the staff member offer to arrange a meeting between you and a staff member?
- How was it to be informed of the death [of your relative] in this way?
- After the death of your relative, what was offered to you by the mental health service? Was it helpful or unhelpful? Are you able to say more about this? How did you feel? What do you now think might have been helpful to you at the time?
- Were you invited to participate in the service review of your relatives care? Were you informed of the findings/lessons learned?
- Are there any questions that you hoped I would ask you?
- Is there anything else you would like to say?

Thank you.

Appendix 7. Letter to family member

Dear [family member]

Letter of invitation (Family)

[date]

I am carrying out a research study looking into how well families were supported when a family member or close friend ended their life by suicide, while being cared for by *Somerset Partners NHS Foundation Trust*.

I am writing to invite you to consider participating in this study.

It may sound really difficult to consider talking to a researcher about your relative or friend after their death, and I apologise in advance if the thought of this is distressing.

However, I am addressing this question in order to make improvements in how we offer information and support to families or carers in this situation. I am very aware that this is a very sensitive subject. However it is also a very important area to try to understand better.

By listening to the views of families and carers I hope that the trust can develop improved guidance when providing support to families or carers bereaved by suicide.

The study:

I am a research student, and for my research I am based at the University of East London and the Tavistock and Portman NHS Foundation Trust.

The research project is called;

“Research into the experience of the relationship between family/carer and staff members from the mental health service after suicide; what are the implications for the mental health service?”

Family members or carers of a client being cared for by the Somerset Partnership, who ended their life by suicide, are being invited to participate in a face to face interview about :

- What happened when the relative ended their life through suicide?
- What it was like as family or carer of the deceased person at the time and afterwards?
- What support was offered to you?

(Staff members involved in informing or supporting bereaved relative or carers are being invited to participate in a separate part of the research.)

If you would be willing consider being interviewed about this subject, I could tell you more about the study, about me and about how your help could make a difference.

I would appreciate it if you would fill in the reply slip and return by using the enclosed stamped addressed envelope *within the next two weeks*.

Completing the slip does not mean that you have to take part , if you change your mind.

Thank you for taking the time to read this letter.

Yours sincerely,

Gina Bird

Appendix 8. Family Information Sheet

Project Title:

“Research into the experience of the relationship between family/carer and staff from the mental health service after suicide”. What are the implications for the mental health services?

I would like to invite you to take part in this research study. Before you decide I would like you to understand why the research is being done and what it would involve for you. The researcher will go through the the information sheet with you and answer any questions you have.

What is the purpose of the study?

Why have I been invited?

Do I have to take part?

What will happen to me if I take part?

Will my taking part in the study be kept confidential?

What happens when the study is over?

What if there is a problem?

Who is the principle researcher?

Who has reviewed the study?

When someone dies unexpectedly many mixed emotions arise and impact upon the family/ carer of the deceased and also the staff delivering care. This is an area that, possibly because of its sensitive nature, has not been researched a great deal. However such tragic events do happen therefore the way the mental health service staff communicate, inform and support the deceased persons family/carer is of utmost importance and worthy of investigation.

We are very keen to ensure we develop and improve ways we relate to family members that experience a death in the adult mental health service. To attempt to address this, I am interested in finding out about the experience of the relationship between family/carers and the staff from the mental health service after the unexpected death of their relative. If people are prepared to join this

study, I aim to talk with a number of family members/carers of the deceased person about they were supported by staff from the mental health service at the time of the death and afterwards.

In addition I will endeavour to separately talk with a number of staff members from the adult mental health service about their experience of being involved with supporting the family/carer after the death of their relative. By this method I hope to gather information from both perspectives, which would after analysis, assist in developing guidelines for staff of the mental health service about how to support families/carers going through the loss and bereavement of their relative. Indeed I hope that this research will help staff to understand more about helpful and unhelpful ways of responding to families/carers so that they can provide the best possible service.

It is very hard when something like this happens, for the family members and the staff involved. If you agree to take part in this project you need to be aware that I am sorry this has happened; however, I will have not been involved in any way with the care/treatment of your relative before their death.

It is anticipated that the interview will take between 60-90 minutes. If you consent, this will be audio recorded. Please see consent form.

I have some questions to help me to structure the interview, and I would also like to ask you about things that come up as we are talking if they seem relevant. This subject is very sensitive and I will endeavour to bear this mind throughout our meeting. It is important that you feel confident to tell me if you would rather not answer a particular question and that you feel comfortable to say if you would like the interview to stop at any time. At the end of the interview I will provide some information about sources of support for people who are bereaved. I hope you will find this is useful.

You are free to withdraw from the research at any time.

The rules of confidentiality will apply to you. Audio tapes of our discussion will be encrypted for additional security and kept in a locked cabinet. When the audio tape is transcribed, all names and any details that might identify you will be changed to ensure anonymity. The interview will be forwarded to you to check the contents and you may alter or change things you wish to before returning it to me. At this point analysis of the information will begin.

At the end of the study audio recordings and transcripts will be destroyed. I will use extracts from the interviews in the write-up of the study. However no participant will be identifiable from this information. I will endeavour to publish the results of the research in a doctoral thesis and possibly elsewhere, for example a professional journal. I will ensure that you will not be identifiable in any published material.

If you decide you would prefer not to take part in the research it will not affect in any way your contact with the Trust.

Appendix 9. Research Reply Slip

With regard to the study

“Research into the experience of the relationship between family/carer and staff from the mental health service after suicide”. What are the implications for the mental health service?

YES I am willing to be interviewed.	<p>Please state whether you would prefer to be contacted by phone ?</p> <p>If so could you please provide details of a preferred time of day/telephone number to be contacted.</p> <p>Please state whether you would prefer to be contacted by letter ?</p> <p>If so could you please provide address.</p>
NO I am unwilling to be interviewed.	

Thank you for filling out this form.

Please return in the enclosed SAE within 2 weeks.

Appendix 10. Letter to charitable organisation

Dear

I am writing to ask you to consider whether you would be willing to help with recruiting potential participants to a doctoral research study. The research project is called:

“Research into the experience of the relationship between family/carer and staff members from the mental health service after suicide; what are the implications for the mental health service?”

To gather information to address this question, family members/carers of clients who ended their life by suicide whilst being cared for by secondary mental health services are being invited to participate in a face to face interview. The aim is to listen to family members’/carers’ views on issues including:-

- what happened when the relative ended their life through suicide
- what and how the mental health trust communicated with the family about the death
- what support was offered to the family by the mental health trust; whether it was perceived as adequate, and what further support from the trust would have been welcomed.

This is a potentially sensitive subject. However, it is a very important area to try to learn more about. It is anticipated that this research will be used to develop guidance for mental health staff when communicating with and providing support to families/carers bereaved by suicide.

I am including people whose relative ended their life through suicide within the last two years whilst receiving care from secondary mental health services.

I am excluding: deaths that have not yet received the Coroner’s verdict; family members/carers who are in the midst of a complaint or litigation against the mental health service, and those who are currently participating in other research.

If you feel you would be willing to write to potential participants and forward them information about the study, I would be very grateful.

This should include:

- a copy of the initial letter
- the participant information sheet
- the reply slip
- a stamped addressed envelope

I enclose copies of these documents.

Thank you for taking the time to read this letter.

Appendix 11. Analysis of interview 1. [Zoe]

Figure 56 Interview Zoe

1	R Thank you for agreeing to sit with me and be interviewed	OPEN CODES INTO THEMES	THEORETICAL/SELECTIVE FOCUSED CODES
2	you have read your participation information sheet are there		
3	P No		
4	R It mentions the consent form if you would not mind?		
5	P Yes I can sign that		
6	R if you could initial the boxes, sorry		
7	the ethics committee have asked that that happens		
8	shall we do a second copy or are you happy that I photocopy that one?		
9	P Yes that's fine		
10	R No further questions?		
11	P No		
12	R What I have here is an interview schedule or guide		
13	which is remind me to ask questions and guide discussion to ensure I cover		
14	the areas needed and the recorder is encrypted so everything is confidential		
15	P nod		
16	R I will transcribe the interview and share it with you to check the contents		
17	so that you change anything you want to change.		
18	The research title is ...& the implications for the mental health services		
19	families will hopefully be interviewed and also a sample from mental health staff		
20	You are the first, the pilot.		
21	P Nod		
22	R This is being done with the intention of feeding the findings being complied		
23	into recommendations into how do this in an improved way because		
24	we know that we could do better when communicating with families and carers.		
25	P nodding		
26	R so that setting the scene is that ok?		
27	P sure [nodding]		
28	R I'll start if it's ok		
29	by asking you to tell me a bit about the reasons you came into the job?		
30	P I've always been interested in people		
31	always interested in what people do and how they work		
32	I actually lived right next door to an old institution		
33	[laughing] it wasn't my first choice of job [smiling]		
34	um (.) my boyfriend's mum		
35	also worked in the institution she would talk about it		
36	and she took me around the institution		
37	and um I applied		
38	and that was thirty odd years ago		
39	and I've never looked back		
40	and I've never wanted to leave		
41	um so I can't say it was a vocation		
42	but I think the interest in people and behaviours		
43	what makes people do things		
44	how people tolerate tolerate different things has always been an interest		
45	R Thirty years is a long time and therefore		
46	I am assuming I don't know		
47	that you will have had um		
48	experiences of having lost people through suicide?		
49	P yes quite a few		
50	quite a few experiences as a care coordinator		
51	or a named nurse in those days		

Introduction, preamble.
Consent form discussed and agreed.

Brought into the job through interest in people.
How people tolerate

Relationships

Experienced patient suicide as a Care coordinator & when Managing teams

52	to managing managing teams that have had a suicide	Poor training for the aftermath	
53	R Did you ever have during career any training around either how to manage	Lots of	Relationships with the family, whether there was a CCO
54	telling of families or post suicide	Suicide prevention training	
55	is there a time you have training?	Training weighted towards suicide prevention	
56	P Had training on what happens after suicide		
57	that's been very poor		
58	we've had lots of training over the years about how to prevent suicide		
59	how to recognise the signs and		
60	but actually there's not a lot of training	Dealing with/supporting families, dealing with Staff and other services.	Speaking from experience
61	on what actually happens (.) .hh when	Breaking Bad News (BBN)	
62	and that's not just dealing with with families	Telling relatives someone has died	
63	its dealing with staff	Reality of what happens	
64	its dealing with other services	Dealing with staff and families.	Poor training.
65	.hh its dealing with (1)		Training needs to....
66	had some training on		
67	had some very good training on coroners courts	Develop own style	
68	um but there isn't a lot	Develop certain skills	
69	seems to be weighted at the prevention end.	Develop / learn how to do it.	
70	R So things like when there is a need to impart breaking bad news		
71	you know breaking bad news		
72	tell people that something has happened to their relative		
73	P u huh mm [nodding]		
74	R either to the relatives or telling members of staff when someone's died	Relatives are guinea pigs.	
75	has that been a kind of a thing that you have	Every time different	
76	something that you have developed over time	Each time completely new.	
77	your own kind of style of doing it?		Multiple roles of manager
78	P Its something that you develop over time		Dealing with/supporting staff, family, others.
79	and ^ I think its hard to develop		
80	because you can develop certain skills		
81	and you can learn from .hh how you do it but		
82	but in a way the poor relative is a bit of a guinea pig	Known family-staff (CCO)working with family- Communicate with parents/ families different	
83	R u huh mm [nodding]	v's unknown family, with little/no relationships with service.	
84	P because you're learning from it .hh and every body's different		
85	every circumstance is different		
86	so every time you're faced with this its like something completely new		
87	because its very different		
88	if there is a care coordinator there that's worked with the family		
89	that knows the family and working with them		
90	its easier to in a way to break that news		
91	but if there is a strange family		
92	who haven't been happy with services		
93	it's a guilt and blame culture there	Family unhappy with services.	
94	that's very different		
95	.hh so it's .hh yeah it's hard		
96	R yes so what you are saying is it's almost like a new thing to do each time		
97	P because it's a very different set of circumstances each time	Guilt and blame, blame culture	
98	and each one of them had a care coordinator who interacted with the parents	It's hard.	
99	the parents could see that everyone was doing the best possible job		
100	all working together	Services doing their best- in spite of efforts suicide still happens.	Each time completely different, feels the first time.
101	but despite all of our efforts		
102	.hh (2) this happens		
103	and there's no blame		
104	to the family or no blame to the services	Blame- no blame-much blame.	
105	it's a very different way than if you have somebody who's		
106	.hh hasn't necessarily engaged		
107	or the the person hasn't let us get engaged with the family		
108	the family feel at odds because they can't	Engagement- no engagement- much engagement.	
109	they are trying to engage and we are being told we can't tell things		
110	it's a very different relationship and		
111	and sometimes you can feel there's a blame		

	culture going on		
112	and and it's it's very different approach	Family feel at odds.	
113	even with relatives that well you know		
114	you just don't know the relatives	With- hold	
115	you actually you'll contact somebody you've never met before	information/telling.	
116	how you you don't know before		
117	how they're gonna react		
118	you don't know their story if you like	Felt blamed.	'Emotion' related to suicide
119	and um and suicide 's such a .hh devastating thing	Some apply a different approach.	
120	when when you you know as a nurse over the years		Emotions when someone dies from suicide
121	telling people .hh (1) that people have died		
122	due to illness I mean that's a hard thing to do	Dependent on relationship/engagement	
123	but it's something beyond your control	Don't know their story	
124	.hh and suicide is beyond our control sometimes	Turning help away	
125	but sometimes it feels like it should be (.) .hh within our control	Suicide such a devastating thing	
126	and that feels very very different	Professional experience	
127	very different in telling	The business	
128	and I think there's a	Telling	
129	there's a guilt around (3)	What to do? When, what	
130	or people feel guilty	how who	
131	.hh and investigations start	Telling about suicide	
132	and you know people want to know why	feels different	
133	and um and I think I think that makes it	Suicide is beyond our control	
134	and then you know it's going to go to coroners court	Guilt	Death by suicide is different.
135	or or so you know well what people are saying	Investigations	
136	and I think people are totally devastated aren't they?	Coroners court	
137	R mmm	Formal informal	
138	P and so .hh (2) it is very different	processes	The business of telling about suicide-'breaking bad news'.
139	very hard and often people say they don't want the help	People want to know why?	Guidance needed about What to do, say, when, how by whom?
140	and then you think how much of that is that they don't want it	People totally devastated	
141	or that they have had a phone call from somebody out of the blue	People say they don't want help	
142	that they don't know	Help not wanted	
143	.hh when they're they're in that a kind of denial stage	Denial	
144	or they're not actually accepting	Not accepting help	
145	in that emotional place	Emotional place	
146	where they have not actually accepting what's happening	Turning help away	
147	they're turning away help	Do you keep going back	
148	.hh how often do you keep coming back?	You don't know what's going on for them	
149	R what do you do about that?	Unknown what to expect	
150	Is that something that you	What to do?	
151	I don't know	What when how who, etc.	
152	is there guidance do you feel around what needs to happen around that	Guidance needed	
153	or is it kind of on a case by case?	Make contact with family	
154	P There's not a lot of guidance	offer things at the start	
155	well not that I've seen	Then offer again afterwards	
156	I think the trust stance would be that you phone up and then	People change their mind	
157	what I usually do is leave a contact number	Speaking from experience,	
158	and then follow it up with a letter	Protection	
159	you know with an open with a reminder	Personal disclosure.	
160	that people can and I often say to people	BBN is hard work	
161	you might not feel you need our help now	BBN to family	
162	.hh but if you change your mind in a weeks time	Fretted avoidance	
163	and feel differently so		
164	but you don't know because you you don't time that phone call		
165	you don't know what that person is doing at that time or they (2)		
166	.hh so it's very strange to have a		
167	.hh and I think .hh		
168	judging from my own experience when my mum died		
169	we had lots of phone calls		
170	and to be quite honest I don't know what I was		

	doing (2)	techniques	say they don't want help
171	.hh and maybe we need to offer things at the start	Anxiety/fear getting in the way	People change their mind.
172	then maybe we need to give a period of time and offer again	Suicide death is different than death by physical cause. Delay tactics.	
173	I don't know	Relationships not established.	Emotions related to suicide-acceptance/ Denial by family/staff
174	R and like you say it's really difficult because there is that kind of sense of	Make contact	Protection/feeling vulnerable
175	perhaps perceived guilt and lots of emotions	Give condolences	
176	the family will be going through lots of different feelings	Saying sorry	
177	it's really hard to remember I'm sure but	Ask if there is anything that they need?	
178	what do you do what have you done in the past	Offering support	
179	with regard to even speaking the words	Some grateful, some ungrateful	
180	what kind of language have you used when you've been in that situation	Some really chuffed about contact	
181	P I think it's quite hard isn't it and to be quite honest	Some aren't – one word answers You don't know their story	
182	if I was really honest	One way conversation	Give condolences
183	I would say I don't remember what I say to people	Don't know what to do	Say "sorry"
184	I've fretted about phone calls	Met with anger	
185	you know I think		
186	and I've done the avoidance techniques		
187	I've done that more than I would do		
188	if somebody died in hospital of an illness		
189	I'd be very clear about phoning somebody straight away		
190	I mean the example I could give		
191	I mean the just recently we had a discharged patient example I could give		
192	committed suicide and I thought well	Uncertainty about what to do	Some grateful, some ungrateful.
193	I must phone his brother up	Send information	
194	because he did phone in	Relationships make a difference	Uncertainty about what to do
195	and that's what started a welfare check		May get into trouble who supports the managers?
196	I'd never met his brother before		
197	um so I phoned up		
198	I put that phone call off for three days		
199	before I did it	Making contact with strangers	
200	.hh I found lots of avoidance techniques		
201	and when I did phone		
202	it sounded like the brother was travelling		
203	in a car or something		
204	so I said can you speak		
205	and he could	Hard afterwards	Where to record contact with family?
206	and I gave my condolences and said who I was	May get into trouble who supports the managers?	
207	and that I had known this man		Making contact with strangers
208	and you know was there anything that we could do to help practically		Emotions getting in the way.
209	or to support the family		
210	.hh as it was quite a traumatic thing	Where to record contact with family	Guidance from organisation
211	.hh they were very grateful	What where when how by whom	needed about what to do;
212	very grateful some people aren't	no guidance	When, how, by whom, to whom .
213	and I asked if we could attend the funeral		
214	and I think they were very pleased because		
215	I don't know how many people were going to the funeral		
216	but they were very pleased		
217	and he was saying		
218	he then said people could come to the wake	Suicide the most dreaded thing we do	Make contact-
219	and we talked about that	Suicide phone call to families to offer support	Provide information to family
220	and then I phoned him the next day		Phone/visit, follow up contact.
221	because somebody an ex team manager		
222	who'd known this man wanted to do a little speech at his funeral		
223	.hh so I phoned up to say	Conversations of a different kind	
224	could I give the number to this man		
225	they were really chuffed that people were actually taking part		
226	that was quite quite easy that one	Suicide is different	Relationships make a difference.
227	other ones you .hh you do all that and you get a one (5	Saying the words-	
228	you get a well you ask are you alright	" I'm really sorry"	
229	I mean how silly is that question (h) ((laughter))		

230	.hh and you can kind of feel it very stunted		
231	and you think do I phone them back		
232	are they angry with us what do you do		
233	I have started sending people the book you gave me	Feels strange	Managers need support during and afterwards.
234	um but it's very hard	Mixed up	
235	it's not something		
236	If it is somebody we looked after for a long time and we've known	Don't know what to do	
237	known the relatives	How much do you pester?	
238	there was another lady .hh and we'd known the relatives		
239	then it doesn't seem (2) because you have that relationship	You don't know their story	Most dreaded thing Death by suicide is different. Saying "sorry".
240	already you have that bond already if you like		
241	but most of the time you're phoning people you've never spoken to		
242	hh so it's (3) I don't know what I say		
243	it's one of those conversations where you have		
244	.hh and it's quite hard afterwards		
245	where do you record it		
246	do you record it		
247	I can remember once I got into trouble		
248	for not phoning the relatives		
249	and I'd actually written in the carers notes		'Searching for resilience' in family
250	because he was open as a carer has carers notes		'Searching for resilience' in staff
251	so I had put everything on the carers notes is what I had been doing	Suicide is awful, awful	
252	and of course the trust had looked in the patients notes	for relatives	
253	so there's no guidance do we	Awful for staff	
254	do the conversations with the relatives go on the patients notes	CCO makes a difference	Good relationships between family/ staff make a difference.
255	or do they go on the carers files	No relationship with family makes a difference	
256	sometimes they've got a carers file		
257	but um (3) and if they have carers support		
258	can we initiate something like carers support going out		
259	who might have a relationship with them	Relationships may not be good relationships.	Blaming organization
260	but it's		
261	I think it's the most dreaded thing you do		
262	is a suicide phone call to families		
263	and you're not actually telling them of the death		
264	most of the time they know		
265	the police do that		
266	.hh so it's about it's very different isn't it		
267	where as if somebody dies in hospital sometimes		
268	you're informing them of a death or you're informing them		Management is lonely.
269	I think you need to come into hospital		
270	as they have deteriorated		
271	um but somebody that they actually know		
272	so you're actually phoning up saying this person was in my care		Managers supporting others, who supports them?
273	they've died	Good relationship with staff	
274	I'm really sorry	Best person to deliver bad news	
275	what can I do to help you	Backed up by others- what, when, who how by whom	
276	and that feels like a very strange place to be		
277	so very mixed		
278	and a lot of people you get one word answers		
279	how much do you pester them		
280	R but like you say if you're ringing and then following it up by a letter		
281	it's leaving the door open		
282	P yeah and I always say you might feel like that now		
283	but if you think it changes		
284	in a few weeks time or when ever		
285	give us a phone we'll be here		
286	because you can't imagine loosing somebody by suicide (...)		Managers need to keep it all together
287	it must be awful for the relatives		
288	it's awful for the staff		
289	quietly] awful for the relatives		
290	R who decides who rings the family		

291	makes what happens in your experience	Searching for resilience in family Searching for resilience in staff	'Training needs to'... support staff, open discussion, what they did, how it went, what could be improved.
292	maybe currently or in the past		
293	P the last few suicides that we've had		
294	we've have quite a few over the last, couple of years		
295	I've phoned (.)		
296	mainly because there was no care coordinator		
297	in any of them		
298	that had really um (..)		
299	really developed any relationship		
300	one was just picked up by a care coordinator		
301	another one had just moved to PD services	Good relationship between staff & family- best person to BBN, with back up.	Suicide in context.
302	um another one had (..) had a care coordinator		
303	but their relationship hadn't been a particularly good relationship		
304	um and he had a young son who I phoned		
305	um but the son was quite (...)		
306	he was quite resilient		
307	I think this had been an ongoing (.) thing for years and years		
308	and actually his dad had actually achieved it		
309	so it wasn't out of the blue		
310	um I I did phone up (..)		
311	I spoke to one of their mothers	BBN usually falls to manager.	Working with families, sharing information.
312	at about the same time as the police		
313	but then I also did speak to one of the flat mates		
314	one of the people had kind of on and off flatmates		
315	so its (4)		
316	if there was a really good		
317	if there was a care coordinator		
318	who had a really good relationship with somebody		
319	or somebody who said I really know that family		
320	think they would be the best person to deliver it		
321	backed up if they felt in that position to do it	Formal delays (police) Relatives unknown Confidentiality/consent Nearest relative, who to contact? How, who, when, by whom. Guidance needed.	Confidentiality/consent.
322	but it usually falls to team manager		
323	who usually doesn't know the family		
324	R are the details though easy enough to find on patients records		
325	in terms of their nearest relatives		
326	P from my experience they are		
327	and usually if you've spoken to the police		
328	have dealings with the police		
329	there was one of them when you know		
330	the police said please don't make any phone calls until we phone you back		
331	to tell you that ^ we've (..) we've told all the relatives	Limitations of who to tell/contact Those most affected- friends, neighbours. Family taken off guard You don't know their story Take it the wrong way Managers supporting others, what about them? Manager supports staff Manager supports relatives No support for managers Deals with this and that Coordinates this and that Works on formal processes Answers questions	Managers support. Support that works.
332	which is fair enough so		
333	you know the police are pretty good in these situations		
334	um and they do tell us if they have		
335	and sometimes it comes to light		
336	somebody will say so and so had a sister and		
337	I mean you can't go through the whole extended family and can you		
338	sometimes it's not family it's friend		
339	sometimes it's not so much the family		
340	we phone the family because they are the nearest relative		
341	but actually the people that are most effected sometimes	Emotion related to suicide.	Formal and informal processes after suicide. Fear of being in trouble.
342	not the nearest relatives (..)		
343	their carers (..)		
344	um neighbours (..)		
345	they're the ones more effected		
346	and there's not always ways of checking		
347	unless we know the person really well		
348	and we know there's a care coordinator knows them		
349	the neighbour across the road had this relationship		
350	or he had a very good friend that comes in		
351	^ you don't know who to support	Emotion related to BBN Hearing bad news BBN to family BBN to staff.	
352	R sounds like it a kind of (..)really really hard		

353	hard to determine how its going go	All look to manager	
354	I think what you're saying is		
355	it's more likely to go better if there's some knowledge or relationship		
356	prior relationship with the family		
357	rather than somebody you've never met or who have no knowledge or	No one asks-how are you?	'Training needs to'.....
358	P and what time do you phone		
359	you phone on the mobile and they're at work		
360	^ or they're in Tesco's		
361	they're not going have a good		
362	they're going to be a bit abrupt		
363	^ are you going to take that as wrong		
364	^ there are so many variables to it		
365	like you can't guarantee that you'll be phoning somebody		
366	as they are sitting down		
367	at home nice and peaceful and being able to think		
368	R so thinking about the doing of that really difficult task		
369	has anybody gone to you afterwards and supported you	Being lucky-having informal supports.	Family expectations, family ability to deal with mental health/problems.
370	with that process of having to impart or break bad news		
371	P I must admit I am going to be very selfish here	Some aren't so lucky.	Family blame.
372	when suicides happen we put a lot of ^ support into		
373	the staff we put a lot of support into the ^ the relatives		
374	but no support goes into the managers		
375	the managers often are the ones that have to		
376	support the staff	Need to keep it all together.	'Family/service mismatch'.
377	they have to deal with the aftermath of the suicide		
378	they have to deal with the police		
379	they have to (.) look at staff from an inquiry point of view		
380	they have to deal with the relatives		
381	they have to deal with everything	Might be unfortunate-no support for managers	Suicide in context.
382	and coordinate everything	no support from organization.	
383	and keep everybody else happy		
384	and you know the management will say		
385	have you debriefed the staff		
386	have you done you know		
387	nobody will ever say		
388	the person coordinating all of this		
389	^ how they are		
390	because they don't ever	Fear being in trouble.	
391	and then you go from the actual incident		
392	dealing with all of that to maybe the next couple of weeks	Emotion related to suicide.	
393	you're working on inquiries and reports and things		
394	and ^ trying to look after staff		
395	maybe ongoing support	Trust asks questions where is the care plan ?	Organisation blames.
396	^ keeping people informed		
397	because everybody wants to know when the funeral is		
398	and they look to the manager to find that out		
399	and then you're answering questions about what happened		
400	and you're looking through files	Trust blaming	Guidance needed for managers and staff about what to do after suicide.
401	and it kind of goes on but	Where is the risk assessment ?	
402	no one ever says		
403	R do know what might be helpful for you in that situation		
404	P I think sometimes just somebody to talk to	Has support been given	'Training needs to'....
405	it's just it does not need to be (..)	Offering support, listening.	Prepare staff and ensure managers provide support and are supported.
406	formal I think if you can find somebody		
407	and I'm lucky I've got a couple of people		
408	on site that I know I could to and say		
409	^ and they say to me are you alright		
410	And I could say oh it's been awful		
411	you know		
412	and or they'll come along and say is there anything I can do	Advice.	

413	or are you alright		
414	so I'm in a very good position		
415	but I think for some managers they're not so lucky		Learning lessons.
416	um you know		
417	you can be in a unit in.... or		
418	where you're the only manager out there		
419	and you've got to keep together for everybody else	No training Commonsense Training needs to....	
420	you might be unfortunate not to		
421	not to have the support that I've got		
422	so I don't think the organisation supports us	Open discussion about what we did-	
423	but I think locally people support us	What we do	Working together to improve.
424	and I think once once staff get over that initial oh my god	How we felt.	
425	and am I in trouble and everything		
426	in a way then everybody starts supporting in a 360 degree		Emotion related to suicide.
427	you know and I must admit our consultants are good	Sharing experiences learn from experiences.	Don't know what to expect.
428	when we've had suicides our consultants have said to me		
429	but I don't think the organisation does		
430	it just starts to go in that big (.) you know	What could be done differently.	
431	has the care plan been done		Relationships, working with families during care.
432	has this been done		
433	you know have we managed this and we done ^ [sigh]	What could be done better .	
434	R just checking my list of questions		
435	because I think just naturally we've covered most things	Improving things.	
436	so what you're saying is you ring and then send a letter		
437	do you ever suggest meeting with families		
438	P I've offered to people we have offered to meet people	Just discussing what you did.	
439	um (..) thankfully nobody's ever said (.) yes		Provide families with practical support, information after suicide.
440	I mean I say thankfully I'm not quite sure what I'd do if they said yes		
441	I suppose the only thing you can do is listen	No set pattern no process.	
442	offer support		
443	but nobody's ever said yes		
444	but I have offered to meet people		
445	provide advice and support	Everybody's grief is different.	
446	but there's no training on what you would do		
447	post ^ you know		
448	we would (..) your common sense	Experience/prior knowledge of the deceased relationships.	
449	your training would lead that		
450	it's (5)		
451	R so it feels that's a difficult question to ask isn't it		
452	because in a sense you have chosen this profession		
453	so you'll be really really skilled at working with people		
454	is there any training you feel would help	Very different reactions.	
455	P I think (.) maybe just having an open discussion		
456	I mean again about what what would you do you know	Offer practical advice. Practical support.	
457	what do we do		
458	what do we feel like		
459	how can we support each other	Info advice.	
460	sharing experiences		
461	you know I made this phone call and this happened		
462	I don't think I handled it very well		
463	you know what could you have done differently		
464	and somebody might say you know		
465	if somebody wanted to come in		
466	you know I did offer		
467	the man that hung himself		
468	his son he didn't want to was very young I think 18		
469	and I said if you want to come in to talk		
470	or if you need anything		
471	He didn't want to		

472	and I did phone him back again		
473	you know he was ok		
474	^ um (..) it would be common sense		
475	it depends		
476	but sometimes I suppose it's that useful bit of		
477	just discussing what you did		
478	what could have been done better		
479	what(..)cos again		
480	I don't believe there is probably a set pattern to follow with people		
481	it's about it's a living thing isn't it	Emotion-	Relationships with the family, whether there was a CCO
482	cos everybody's grief is different	what to expect from family.	
483	everybodys experience of that person that have died		Speaking from experience
484	it's very different		
485	reaction to what's happened is different	If they blame us.	
486	we always offer practical help and sometimes people take that		
487	they say ^ you know	Emotion-blame.	
488	I don't know what to do about this		
489	and I don't know what to do about that		
490	we've sent out people		Poor training
491	You know people have got stuck on	If they weren't happy with service.	Training needs to....
492	you know I have to shut down the benefits		
493	I need to get housing		
494	you know it's all too overwhelming all the practical things	Family/service mismatch.	
495	um so people don't know	Family make contact	
496	who to phone for the benefits I don't know	sometimes have unrealistic expectations of service.	Multiple roles of manager
497	so sometimes it's about phoning them back and giving the benefit number	Blame us, find fault, criticize.	Dealing with/supporting staff, family, others.
498	giving the numbers and they are happy to do it themselves		
499	or there are times when we've gone down with people		
500	so it's that kind of	When everything is ok	
501	which is what we'd do for any death really	no apology from family.	
502	and we'd provide that for anybody		
503	but its those practical things	Relatives abilities	
504	things people kind of (...)	relationships/knowledge of family.	
505	R that's really encouraging that not only is there information		
506	but practical support		
507	P yes sometimes that's the hardest	How they deal with things.	Telling- Breaking bad news is hard.
508	you've got a persons life to shut down haven't you		
509	you've got bank accounts to shut down		
510	you've got ^ um benefits to stop or		
511	people to tell	Previous relationships within the family.	
512	people are unsure of what to do	You don't know their story	
513	sometimes they're not sure about funerals		
514	sometimes there's no money to bury somebody		
515	it's about you know how do they go about that		
516	so its just practical		
517	R You suggested things probably go better if you've some sort of relationship		
518	Are there any other ideas about if things go better or worse	Difference in ways of dealing with mental illness.	
519	P I think sometimes its its about whether they blame us or not		
520	whether they are happy with the service or not		
521	some people will say (..) you know^		
522	you've done everything they can	Difficult to place suicide in context.	Each time completely different, feels the first time.
523	other people for various reasons feel unhappy with the service		
524	even when their relative/friend is alive		
525	and that might be		
526	because they want to be involved	Panic in family after suicide for other family members.	
527	and the person doesn't want them to be involved		
528	or they all want us to do unrealistic things		
529	that we can't do and ^ (..)	Poor relationships in the family.	Difference in relationships if family known/not known to services
530	cos you've got a blame (..) there before you started		
531	you get those phone calls		
532	you know somebody sets a suicide date		

533	then we get frantic phone calls	Trying to make sense of suicide?	Managers support.
534	^ if you don't she's going to kill herself		
535	and it'll be all your fault		
536	you know Monday comes around and 99.9% of the time	Collating the jig saw puzzle.	
537	the persons there and we don't get an apology to say		
538	you know		
539	but [sigh]	Everyone brings something to the table.	
540	if that kind of scenario happens		
541	I think that		
542	I think sometimes it's about the relatives own abilities	See the bigger picture.	
543	either intellectually or emotionally to be able to deal with something too		
544	some people ^ can	Piecing together	
545	some people can't or they do in a very different way	No one should be alone in management who supports managers?	Emotion related to suicide
546	one man that was very rigid	No one should be alone as a care coordinator	
547	very black and white	Suicide is terrible	
548	and it's like the the suicide was very ^ difficult to place in that	No one should be spotlighted, everyone distanced	Emotions when someone dies from suicide
549	and ^ um and (3) I don't know how much support they're getting	Organization makes that a risk	
550	and what they actually thought the relationships were	support processes absent.	
551	and one	Some senior managers move straight to	
552	there was a young girl and her relationship with her mum	Formal processes blaming	
553	wasn't the best of relationships	What, when, how, who...	The business of telling about suicide-'breaking bad news'.
554	and you know when I spoke to mum	risk assessment, care plan, notes	Guidance needed about What to do, say, when, how by whom?
555	and offered mum support	scrutiny, fear	
556	mum didn't bother about her much in her life		
557	and wasn't that bothered in her death	No one wants to get caught in that	Suicide beyond our control
558	but the people that needed the help were her flatmates		
559	so (..) it's no it's	Some support good no blame, no judgment	Formal processes Coroners court
560	and I think when there's somebody single or not	'enabled' to go through process	
561	you know if they're on their own themselves trying to deal with it or		Families devastated say they don't want help
562	one of them	You're in shock too	People change their mind.
563	one of the suicides we had there were two brothers	Emotions when someone dies from suicide	
564	and the other brother is still in the service	Suicide is a catastrophe.	Emotions related to suicide-acceptance/ Denial by family/staff
565	so there was an immediate panic around protecting the other brother		Protection/feeling vulnerable
566	though he's not suicidal but the parents kind of	Help with writing coroners reports	
567	but it was^ about going with that for a little while	Some senior staff take the wrong approach	
568	they needed to make sure their existing son was safe (..)so	Don't know where we stand	
569	R How do you know how to think to do that	Past relationships between people in families	Give condolences Say "sorry"
570	I'm just wondering how you because you've got information	Staying neutral don't know their story	Suicide in context
571	that you are trying to make sense of which is a shock as well to you		
572	P yes		
573	R so how is that you are thinking about the people directly involved		
574	but also perhaps the wider		
575	P I think its all a big jigsaw puzzle		
576	and everybody does it		
577	I don't think it's down to one person		
578	you have to have the team manager or somebody who's		
579	who's collating it		
580	but my experience is that everybody brings something to the table		
581	and then it's up to ^ you know		
582	we all see that bigger picture		
583	it starts off with something and people say		
584	well actually there wasn't the this		
585	or there wasn't the that		
586	or my experience of that is this or (...) [sigh]		
587	um it kind of gets pieced together		
588	and I think it flows		
589	R sounds like it happens here		

590	do you think it happens in other parts of the trust	Don't know what you're going to get.	<p>Some grateful, some ungrateful</p> <p>Uncertainty about what to do May get into trouble who supports the managers?</p> <p>Where to record contact with family?</p> <p>Making contact with strangers Emotions getting in the way. Guidance from organisation needed about what to do.</p> <p>Make contact- Provide information to family Phone/visit?</p> <p>Relationships make a difference Searching for resilience in family Searching for resilience in staff</p> <p>Good relationships between family/ staff make difference. Formal processes</p> <p>Blaming organization Management is lonely.</p> <p>Managers supporting others, who supports them?</p> <p>Managers need to keep it all together.</p> <p>Training needs to...support staff, open discussion, what they did, how it went, what could be improved.</p>
591	P I don't know I would hope so		
592	because nobody should be left alone in the management		
593	or a care coordinator		
594	or anywhere with a suicide		
595	I think that ^ you know		
596	it would be a terrible thing		
597	for a suicide to happen		
598	and suddenly there be one person spotlighted		
599	and everybody else distanced		
600	the organisation makes that a risk		
601	because (.) although they say they are not going to be judgemental		
602	that they aren't going to ^ a be blaming people		
603	there's an immediate sense of investigations		
604	what did you do		
605	and ^ I kind of		
606	when I hear of a suicide		
607	I feel awful for the person		
608	think of the relatives		
609	think of the staff		
610	and then I think		
611	oh my god		
612	did they have a risk assessment		
613	did they have this did they have that		
614	and I look through the notes checking things		
615	um so		
616	R its automatic		
617	P it is and nobody wants to get caught up on that		
618	and everybody knows when someone's had a suicide don't they		
619	R is there any way that we could do it differently		
620	P My experience of our old		
621	cos a we've got a new risk management team		
622	so I can't talk about that		
623	our old risk management team		
624	I can't say anything bad about that team		
625	in that from the very minute		
626	you phone them up and say you've had a suicide		
627	there's no sense of judgement		
628	no sense of blame		
629	just a sense of enabling you to go through a process		
630	and that was really good		
631	they were very methodical in what they gave you to check		
632	and I think that was very useful		
633	because like you said you're in shock too		
634	and sometimes you've known this person personally		
635	and you've got emotions about them		
636	you now(.) ^ we all have emotions when somebody dies		
637	especially like that		
638	the team very very good at accepting it		
639	not catastrophising it		
640	I mean it is a catastrophe but it's happened		
641	and not judging and being very calm		
642	saying have you done this		
643	have you done that		
644	if you need our help come back		
645	so a and		
646	and right through to the coroners court		
647	you know staff writing reports for coroners		
648	brilliant		
649	writing (..) [sigh]		
650	going to coroners courts and then		
651	in between you usually get a SUI inquiry		
652	they can vary depending who's doing it		
653	I think that some people are very good at doing them		
654	and supporting the staff		
655	and you know		

656	to help to look at are there any learning points		
657	then other staff that aren't helpful		
658	who take a wrong approach with SU		
659	but I think the risk management team are excellent		
660	I can't fault them		
661	I don't know where we stand now in a new organisation		
662	R I'm coming to the end now		
663	are there any questions that you expected me to ask you that I haven't?		
664	P not really no it's a		
665	it's a strange subject really isn't it		
666	not that I can think of		
667	it's a good job we don't have that many		
668	R yes that's right		
669	and like you say if there was training it would help a bit		
670	but its never going to be a one size fits all		
671	P no never and you're dealing with different		
672	you're dealing with parents		
673	you're dealing with brothers		
674	you're dealing with children		
675	you're dealing with		
676	like the mother I talked about		
677	who never had a good relationship with her daughter		
678	that was very hard because her daughter was quite a a [smile] likeable girl		
679	and there was quite a lot of		
680	there was a lack of feeling		
681	or I felt there was an awful lack of feeling there		
682	and you can't let that judge how you behave to mum		
683	because at the end of the day she's mum		
684	you don't know what she's thinking		
685	but sometimes that makes it quite quite hard		
686	and like the dad that was very black and white thinking		
687	a lot of times when you pick up that phone to offer		
688	you don't know what you're going to get the other end		
689	R I think that brings this to a close		
690	thank you		

Appendix 12. Excerpt 1 of Will's interview.

Figure 57 Wills interview

Line	Transcript of interview with Will (Excerpt I)
399	"I've met with people
400	Just, you know
401	Having anticipated the possibility
402	And going quiet with the shock
403	Has been the most common response
404	That I've had.
405	Or people knowing that they've got to
406	Have another awful conversation about something
407	Ha, ha,[laughter]
408	So it's a resignation
409	to the fact that, um, even though
410	They may have talked to another person
411	About what's going on
412	They need to have another conversation again
413	with me
414	And understand why
415	And me trying to turn it into
416	Something therapeutic for them
417 Int	Has that always been the case?
418 Will	Which one, regards as?
419 Int	That you're able to make it kind of?
420 Will	Yes, I've always tried to look for the opportunity
421	To make it a therapeutic involvement
422	Yeah
423	If you've gotta go and do something
424	Um, you try and not make it worse
425	Try not to do harm
426	And then, um
427	See if there's an opportunity to do something
428	In a small way
429	That could be cathartic
430	Or therapeutic for the individual
431	Receiving the
432	Having the conversation with you
433	So there's always a bit of you
434	Keeping an eye on what you know
435	When you're keeping your eye on
436	About four or five things
437	In the conversation
438	One of your eye on
439	Am I making things worse?
440	One of your eyes on
441	Is this something that can actually help
442	In the longer term
443	For this person?"

Appendix 13. Category 2 (Of SC 1. Breaking bad news): Supporting managers supporting others

In the following excerpt Will says managers generally need more support, in his view specifically when breaking bad news. This excerpt is lengthy but important to include as it tells much about the needs, often unmet, of managers and senior staff.

Transcript of interview with Will (excerpt II)

Figure 58 Wills interview excerpt II

Line	Transcript of interview with Will (excerpt I)	
568	"nobody, um (3)	
569	helps, you know.	
570	Um people look into the support	
571	for yourself	
572	and people just accept that	
573	your role is not to receive support	
574	your role is to give it and	
575	um, in the past	
576	when I was actually in the clinical situation	
577	um, nobody thought of asking the question	
578	so you were	
579	by and large	
580	left to get on with it	Diary notes make mention of the mix of emotions, contradictions in what Will was saying and how he was coming across. Being a very senior manager posed me some questions after the interview..
581	so I think	What does this mean?
582	when I was a recipient	
583	I didn't receive it	
584	and being older and um,	
585	giving support	
586	you don't really expect to get,	
587	you know,	
588	you don't really expect to get [quietly]	
589	you're just expected to get on with it really [quietly]	
590	anyway we're middle management senior management	
591	so we've had our emotion cut out."	Words used here sound barbaric and primitive which conjured up more questions. Was Will trying to seem impervious to feelings, perhaps protect himself?

Will's words bring into sharp focus what it meant to him to be in middle management. In the final line Will introduces a sense of irony and talks about the prevailing culture of 'expecting nothing' and having had 'emotion cut out'. This is particularly poignant in Will's case. However the following segments of the interview have been selected to describe how the data analysis evolved from initial line-by-line coding into themes and then subcategories. Without exception the staff interviews spoke of feeling unsupported by their manager or the wider organisation. Again this builds on the analysis of Zoe's interview, for example, lines 418-419:

“When you’re the only manager out there and you’ve got to keep together for everyone else”

Therefore the code of: *‘Management is lonely, who supports managers?’* was devised.

In keeping with the analysis, when coding Will’s interview, when he commented on support in lines 572-574:

“People just accept, your role is not to receive support, your role is to give it.”

This therefore appeared to couple together with Zoe’s code. Whilst supporting and managing staff is part and parcel of managers every day work, the question was posed, “who supports them?” (lines 372-4):

“When suicides happen we [managers] support staff and relatives ... but managers get no support ...”

There appeared to be the expectation, quite rightly some might say, for managers to be available to manage the very complicated processes following a serious untoward patient incident, as described by Zoe in lines 375-385:

*“Managers are the ones who have to support
Staff ... deal with the aftermath
Deal with police ...
Look after staff inquiry perspective ...
Deal with relatives ...
Deal with everything ...
Co-ordinate everything ...
Keep everybody happy ...
Trust management will check ... have you
Debriefed staff?”*

However having addressed and attended to the many different tasks and requirements that follow a serious patient incident, the needs of the person who is supporting the process do not appear to have been routinely considered (lines 387-404):

*“No one ever says – what about the person co-ordinating
All of this? ... How are they? They don’t ever.
You go from the actual incident
Dealing with all of that ... working on
Inquiries, reports ... trying to look after staff*

Diary and reflective notes made during analysis highlighted the struggle and isolation

*Ongoing support ... keeping everybody informed
Everybody wants to know ... they look to the manager
Answering questions about what happened
Looking through files ... no one ever says –
Need someone just to talk to?”*

Zoë's words blended with this view expressed by Will in lines 567-578:

*“In senior management nobody helps ...
People just accept
Your role is not to receive support
you're role is to give support ...
even when in a clinical role – no one thought to ask
you were left to get on with it, being older,
giving support, don't expect it.”*

This presents as a further issue for the manager to attempt to address in what appears to be relative isolation, leaving much to chance, as Will stated in lines 76-83:

“Early experience of being left to get on with it ... Gaining support seemed to depend on chance ...”

Some people, as Zoe states below (lines 406-414) have relationships with colleagues they can call on for support in these kinds of situation:

*“If you can find somebody ...
I am lucky ...
I've got a couple of people I know I could go to
and say ... they say to me – are you alright?
I can say it's been awful ...
they'll ask if there's anything I can do?
Are you alright? ...
in a good position”*

On one hand managers who have a supportive network may have people who will offer to help and support them, and are available to do so. However some people are not in that position and are very much left to get on with it, as Zoe indicates (lines 415-420):

“Some aren't so lucky ... when you're the only manager ... need to keep it together ... might be unfortunate not to.”

The absence of support for managers was raised and therefore, subject to the process of analysis, this became a theme, then a subcategory within the core category of 'breaking bad news'. What seemed to be happening during the course of analysis was the realisation that findings from the study might come up with useful ways that staff could embark on having potentially sensitive conversations with families and patients, as reflected in the quote below:

*"Imagine a colleague coming to me [going to a colleague as] I am dealing with a particular user issue/case and wondered whether you'd join me to see the family to discuss with them ...
basic guiding principles might encourage
that, so you don't feel so lonely there are senior staff about that have
an understanding of that sort of situation" (Vic, lines 467-489)*

However having such conversations is highly delicate and needs to be approached with sensitivity, as such interactions and the specific words that might have been used can invariably be remembered and gather importance, particularly in the context of a suicide. This led onto consideration of the

importance

of thinking through and perhaps rehearsing the words that staff might use when breaking bad news or offering support to family or others after suicide. Once uttered words cannot be retracted.

As Will stated in lines 503-521:

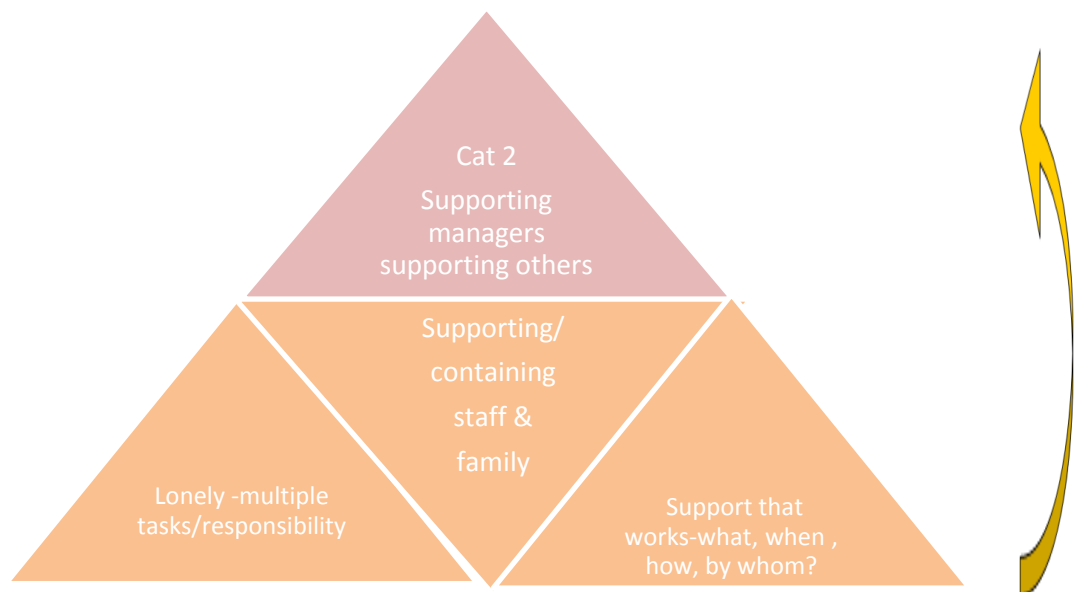
*"doing it properly is about
maintaining your sensitivity
and saying it straight to people
because you know there's one thing
people don't want
and that's 'bull shitters'
and so you try to say it straight with people
but in a sensitive way
so you don't have minced words
but you don't go blunt
cos the danger is
that people through fear
blurt or gurge something out
or try and make it 'mealy mouthed'.
People need it straight but sensitive
so you concentrate on technique
That's what I do with fear
concentrate on technique
and delivering it right, or try to."*

Something ill considered can do untold damage and add to the suffering and distress of bereaved family members and staff, which needs to be avoided wherever possible. Again, in keeping with the theory, I posed questions of the data:

- Whether indeed there is a particular technique that can be employed in such an individual and unique set of circumstances?
- Can staff can be trained towards using such a technique?
- Is this what family members want?

This is discussed later, however you will note category 2, 'Supporting and containing staff and families' (illustrated in Figure 25) later became a subcategory and then Core Category 6.

Figure 59 Category 2 (of breaking bad news): supporting managers



Appendix 14. Subcategory 5: Formal processes (Staff members)

Next I present the subcategory of ‘formal processes’, including an excerpt from Keith’s interview, whose words about his experience of attending a coroner’s inquest particularly influenced this early code, theme and then category.

Figure 60 Transcript of interview with Keith (excerpt I)

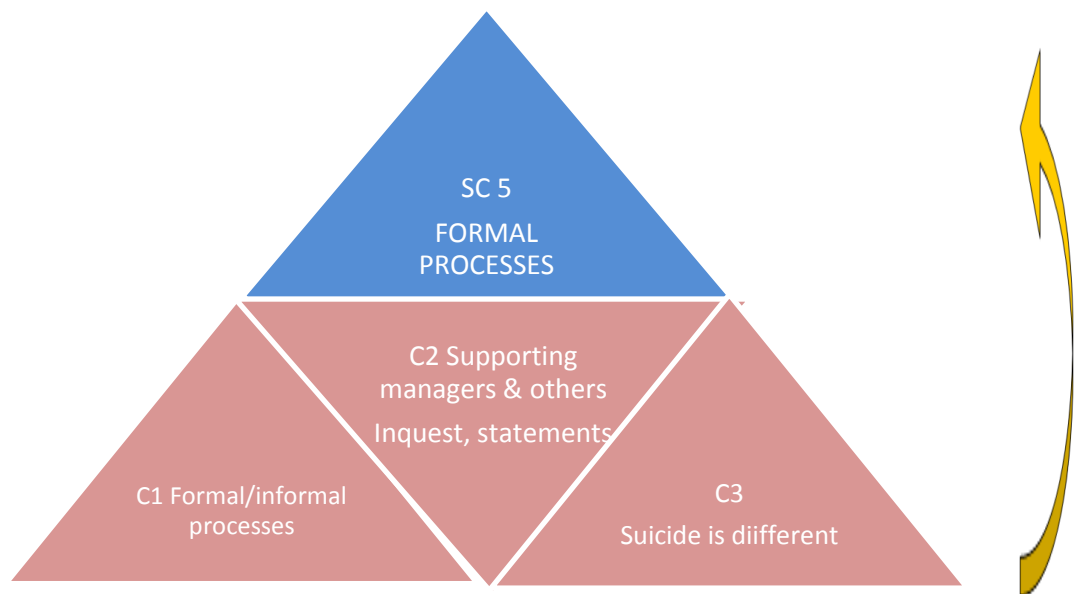
Line	Transcript of interview with Keith (excerpt I)
276	“the tension exists between wanting to (2)
277	support somebody that is in the situation
278	the bereaved family and wanting to
279	finding the words (5)
280	The starkest example of that
281	was when I went to a coroner’s inquest, um,
282	over a chap who took his life in our services
283	and, um, that was an incredibly difficult experience.
284	the coroner was pressing me quite hard
285	as to why particular steps hadn’t been
286	taken at particular points and what have you
287	and the mother and brother of the person
288	that killed himself were sat there
289	staring daggers at me
290	while I was answering questions.
291	And we came out [colleagues name]
292	said to me “oh, that went really well,
293	we got off lightly”.
294	and I didn’t feel I got off really lightly at all –
295	And,
296	I don’t know,
297	it felt like a callous position
298	he’s protecting the Trust’s interests
299	and that
300	that did feel, um, callous
301	I certainly didn’t feel I got off lightly
302	with the coroner pressing me
303	quite hard and appropriately so
304	the obvious, um
305	family, um
306	what [colleagues name] meant was the
307	coroner could have been far more critical of our actions
308	and that, and yeah
309	the sensitivity around bereavement,
310	a vacuum
311	for us as well as family
312	I feel a deep shame
313	that someone we supposedly care for
314	are treating should take their life
315	that I got off quite lightly, yeah.”

Figure 61 Amalgam of field/diary notes and memos

Here my reflections included trying to remember from my own perspective what it was like to attend to the multiple positions for people, professionals in this role. On one hand trying to do your best to provide high quality care and then when someone dies the stark reality of having to face the family and consequences of someone's suicide. The literature suggests that staff experiences of attending a coroner's court can be highly stressful & distressing. From what Keith said, it sounded like he was completely unprepared. The diary note at the time records that Keith's emotions were almost palpable when speaking...he still seemed shocked.

To show how this process emerged, the subcategory below was developed in part from Keith's words.

Figure 62 Subcategory 5: Formal processes



Keith spoke about what he experienced when hearing the words of his colleague and went on to say in the interview that he had afterward addressed the person who made remarks around:

“Having got off lightly”

and in line 352 had the response:

“Maybe I’ve spent too much time doing this stuff.”

Keith went on to say in lines 357-362 that this experience had rated as:

*“The bottom 5 of my professional life
A horrible day in terms of, well
partly I think I felt under pressure to (...)
um, to not to be, but to
to tow the party line, so.”*

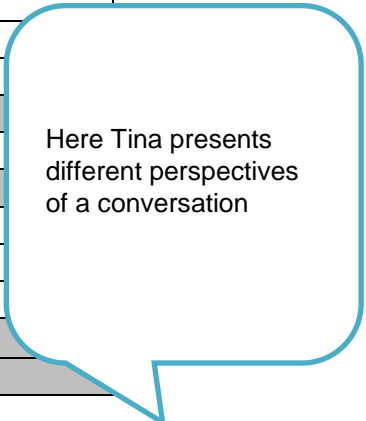
Keith therefore managed to articulate the sense of being caught in the dilemma of needing to ‘tow the party line’ by being the manager of services providing care, whilst appreciating the tensions that existed within that role, particularly if someone dies, and the ‘deep shame’ he felt when faced by this in a coroner’s court. These excerpts are included to provide a flavour of the codes and themes that formed parts within the subcategory but also overlapped into others including that of CC1 ‘Training needs to ...’, CC 2. ‘Emotion’, and what became CC 5. ‘Supporting managers’.

Appendix 15. Subcategory 6: Including families – working together

Throughout all the interviews the staff members spoke about their concerns for the families of the patient that died. A variety of views were voiced which were coded and analysed accordingly.

Figure 63 Transcript of interview with Tina (excerpt I)

Line	Transcript of interview with Tina (excerpt I)
88	"The mother told them [mental health staff] often
89	That she was fearful of suicide
90	And how this person would do it
91	And they [mental health staff] said oh no
92	Everything's ok
93	This obviously raised stress levels and fear
94	And it felt she was
95	She felt she was being um
96	Overprotective
97	Or she was told she was being overprotective"

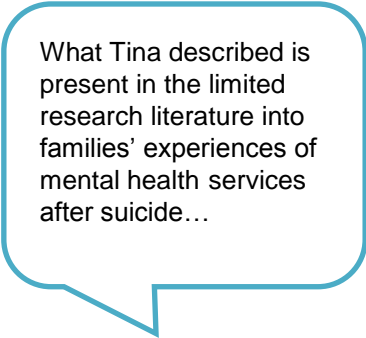


Tina went onto say how families felt in lines 200-201:

"not listened to or even acknowledged or valued."

According to Tina the family felt they could see what was really happening for their relative, indicating that the mental health staff were missing so much important information, as shown in lines 142-154;

*"As opposed to what he was threatening [suicide]
which you know obviously
ended up real
they became very, very angry
and despondent ...
cut off, total cut off
from everything and anything
to do with his life and the mental health situation."*



What Tina described is present in the limited research literature into families' experiences of mental health services after suicide...

Indeed once the reality of the feared situation was understood, they felt they received no support either before or afterwards from the mental health staff, and consequently the family seemed to respond by distancing themselves. This posed the question of what happened to their unexpressed emotion.

Tina was able to offer one possibility (line 166): it was

"Bottled up and festered".

The next excerpt presents some more family views.

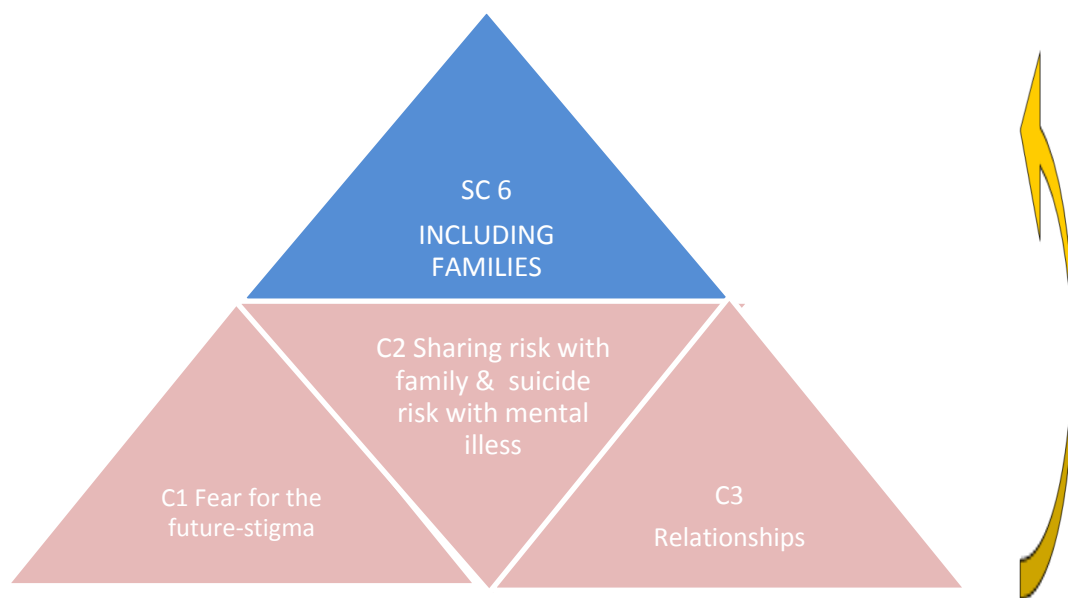
Figure 64 Transcript of interview with Tina (excerpt II)

Line	Transcript of interview with Tina (excerpt II)
130	"and that hurt them very much
131	The fact that, um
132	Well, I say, like he never existed
133	There was no one following up
134	Not that they were feeling
135	Except for myself
136	But what they deserved
137	Was some sort of contact
138	With people that knew him
139	And the treatment he was having
140	And why..
141	Um, why they [mental health staff] felt he was ok
142	As opposed to what he was threatening
143	Which you know
144	ended up real
145	They became very very angry"
146	And despondent..
147	Cut off, total cut off
148	From everything and anything
149	To do with his life
150	And the mental health situation."

What Tina described is present in the limited research literature into families' experiences of mental health services after suicide...

The expert knowledge and experience the family had in relation to the person receiving care does not seem to have been considered by the mental health staff. Indeed Tina went on to say when the family tried to impart information; it was either disregarded or not taken seriously. Tina spoke about her experiences of working closely for many years with families and carers of people receiving mental health services. This was important information and whilst not directly from the family members themselves, resonated with some of the other material in the study. Tina's voice added more depth and quality to the data, consequently adding and culminating in the sub category below.

Figure 65 Subcategory 6: Including families working together



Appendix 16. Subcategory of Emotion related to suicide (Family members)

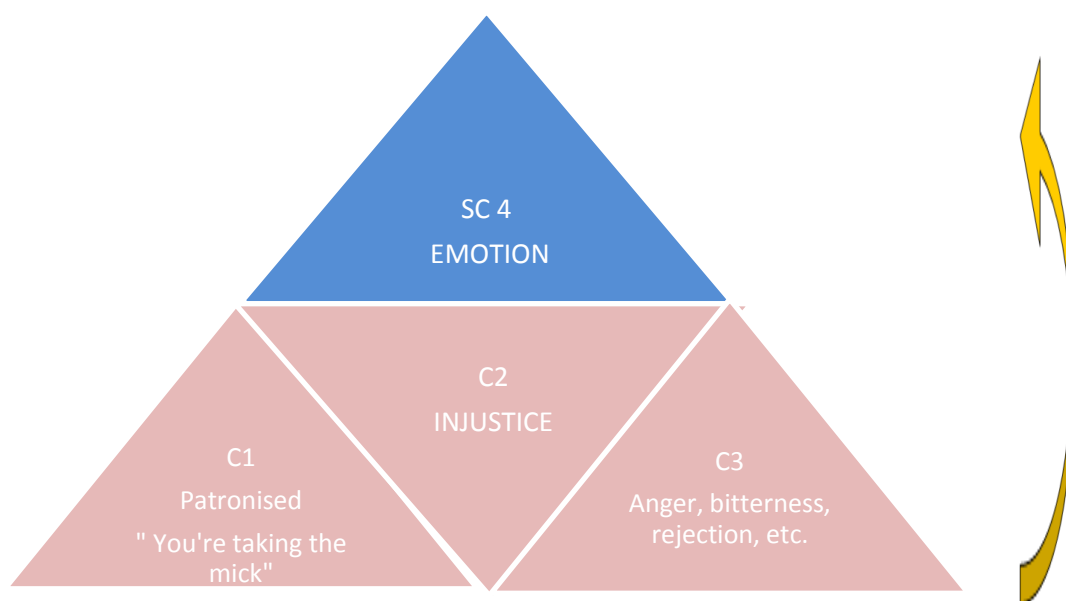
The analysis of subcategory 4, 'Emotion related to suicide experienced by family members', showed all family members' emotions about the way they felt they were treated by mental health services. Brenda, Brian's widow, spoke about the way she felt when she was in hospital with her husband Brian, who had at that time seriously attempted to end his life.

Figure 66 Transcript of interview with Brenda (Bond family interview 1)

Line	Transcript of interview with Brenda Bond family int 1)
684	"yes, we were told nothing
685	and in the end I got so cross
686	I said
687	he was speaking to us as though we were imbeciles
688	and I said "you're treating my husband
689	as though he's a lump of meat"

As previous data analysis the 'emotion' codes were grouped and compared/contrasted to build together the codes into themes of emotion. In vivo codes were used where felt indicated, for example when Bill expressed his view that he felt 'patronised', as category 1.

Figure 67 Subcategory 4: Emotion.



This shows the analysis of emotion as experienced by family members from theoretical/selective coding into the subcategory.

The next part of the analysis of the family interviews moves on to consider the reports about the mental health services compared to expectations and hopes for the families seeking services for and with their relatives.

Appendix 17. Family/service mismatch

In this next part I consider how the family members' aims and hopes for care were perceived by the families, which was felt to be in opposition to what the mental health service provided. Here I attempt to illustrate the way the person presenting for help and the aims of their families ended up not meeting in the middle. Therefore what became the initial code emerged into the subcategory that followed, of the family aims and service care 'mismatch'.

I would like to quote what Chrissie said in her interview in lines 2790-2793, when she was speaking about her attempts to access support out of hours during a crisis for Adam:

*"If you don't offer a service, don't advertise the fact that there is one
And put it on the website because you don't want people to be disappointed".*

This was very much how Chrissie felt about the services that were offered to Adam, as below.

Figure 68 Transcript of interview with Chrissie (Excerpt IV)

Line	Transcript of interview with Chrissie (Excerpt IV)
2801	"because it seems as though
2802	people can say they follow NICE guidelines
2803	and then they can have
2804	all these little clauses written in
2805	you know, that says, ah but yeah,
2806	we'll see you within 24 hours
2807	and that's no good to somebody
2808	on a Friday night
2809	if you've got to wait till Saturday night
2810	and probably Monday morning um, you know
2811	that's not what it's all
2812	but that's what seems to happen
2813	it gets twisted
2814	and then you don't get what it says on the tin"

Diary notes mention after this interview the real sense that Chrissie was in a double bind- hearing & expecting one thing, receiving another not remotely as stated..

There was a growing sense as I was analysing the data from the family members that the way mental health services were arranged and what they provided did not match up to the expectations of the families. This invited the following questions:

- Where the families' expectations about mental health services coming from?
- How well or otherwise do mental health services fit with what people expect from them?

- And experience?

Through analysing the data, reflecting on my memos and diary notes, and reviewing the literature, the links with depression, suicidal thinking, self-harm and completed suicide all blended together. Following this I felt it was important to consider the way mental illness and suicide are coupled together in the dominant discourse.

Appendix 18. Family motivation to participate in the research

The literature in the review outlines some of the reasons people bereaved by suicide decide to participate in suicide research studies. Throughout the analysis what clearly came across was family members' motivations for agreeing to be involved in the research. Chrissie's motivation is captured below.

Figure 69 Transcript of interview with Chrissie (Excerpt V)

Line	Transcript of interview with Chrissie (Excerpt V)
2445	"Story telling from ancient times,
2446	the more you tell it,
2447	I think perhaps
2448	the more real it gets...
2449	Which I think is important
2450	Because it's not real for a long time.
2451	The more real it gets
2452	The more you are able to, kind of
2453	You've got to absorb it
2454	And somehow you have got to process it
2455	And I think in the telling
2456	Is a way to processand
2458Get some kind of,
2459	Well, it's not rational
2460	It is...
2461	But some kind of rationale
2462	In your own mind
2463	That you can say
2464	Well that's probably why
2465	And then you know
2466	And then you can move on
2467	And say
2468	Is there something I can do
2469	That could make a difference
2470	To somebody, you know?"

Reflective diary notes afterwards comment on the mix of feelings- from Chrissie a deep sense of wanting to make a difference, as she said, "can one voice make a difference?" ...

This reverberated for me and served as an inspiration to redouble my efforts as just 'one voice' to carry on with the research at times of flagging energy and reserves....

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